Arizona Medicine

JOURNAL OF ARIZONA MEDICAL ASSOCIATION

MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

Volume 18 Number 7

July, 1961

inside as well as outside the hospital...
staphylococci usually remain sensitive to

CHLOROMYCETIN

(chloramphenicol, Parke-Da

That the sensitivity patterns of "street" staphylococci differ widely from those "hospital" staphylococci is a well-established clinical fact.[1-5] Although strains staphylococci encountered in general practice have remained relatively sensitive a number of antibiotics,[6] the problem of antibiotic-resistant staphylococci appe to be a threat to all patients in hospitals today. It is encouraging to note, howe "...that a relatively small percentage of strains develop resistance to chlora phenicol, despite the consumption of large amounts of this antibiotic."[7]

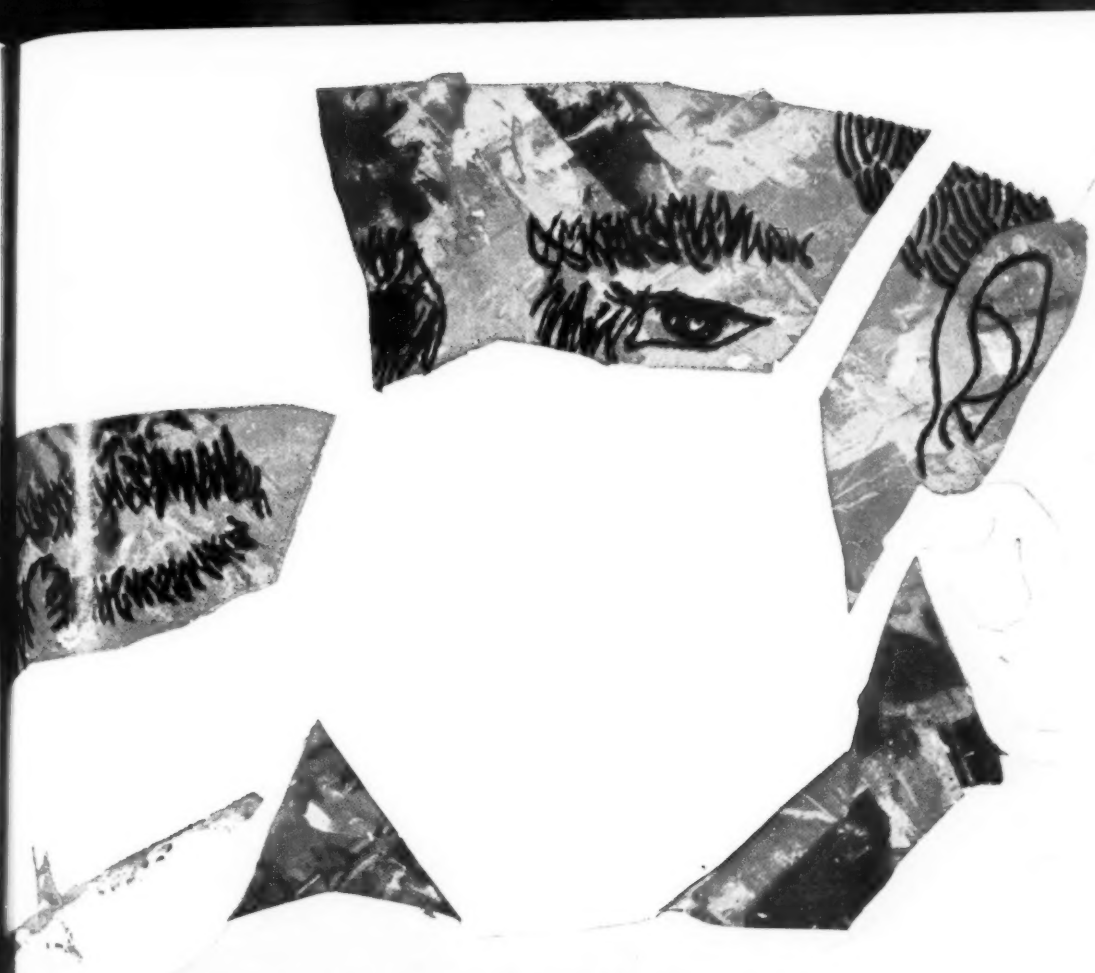
In one hospital, for example, CHLOROMYCETIN "...was the only widely u antibiotic to which few of the strains were resistant."[8] In another hospital, desp steadily increasing use of CHLOROMYCETIN since 1956, "...the percentage chloramphenicol-resistant strains has actually been lower in subsequent years Elsewhere, insofar as hospital staphylococci are concerned, it appears that "...t problem of antibiotic resistance can be regarded as minimal for chloram phenicol

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various fo s, includ Kapseals® of 250 mg., in bottles of 16 and 100.

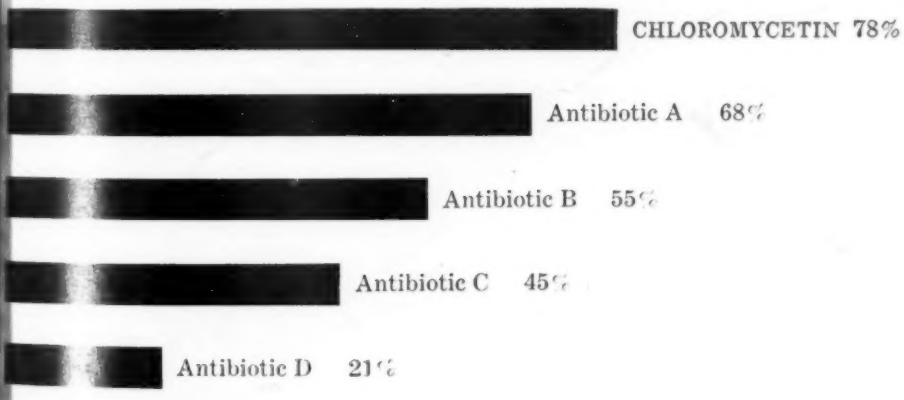
See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, th mbocytope granulocytopenia) are known to occur after the administration of chloramphenicol. Blood scrasias h occurred after short-term and with prolonged therapy with this drug. Bearing in mind th ssibility such reactions may occur, chloramphenicol should be used only for serious infections cau by organ which are susceptible to its antibacterial effects. Chloramphenicol should not be used en other potentially dangerous agents will be effective, or in the treatment of trivial infections su s colds, enza, viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with drug. W blood studies may detect early peripheral blood changes such as leukopenia or granuloc penia, bef they become irreversible, such studies cannot be relied upon to detect bone marrow de sion prio development of aplastic anemia.



IN VITRO SENSITIVITY OF 250 STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN AND TO FOUR OTHER ANTIBIOTICS*



These strains of coagulase-positive staphylococci were isolated from hospitalized patients at a large county hospital during the year 1959. Sensitivity tests were done by the disc method.

*Adapted from Bauer, Perry, & Kirby[1]

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Arizona Medical Association Reports

Arizona Medicine

July, 1961 Vol. 18, No. 7

Board of Directors Meeting April 28, 1961 Minutes Board Organization

Doctor Yount welcomed and introduced the newly elected members of the Board of Directors: Doctors Clyde Barker, Jr., (1961-64), W. Albert Brewer (1961-62), John A. Eisenbeiss (1961-64) and Noel G. Smith (1961-64), all of Phoenix, Central District Directors; Joseph P. McNally (1961-64) of Prescott, Northwestern District Director; Earl R. Baldwin (1961-62), James O'Hare (1961-64) and John R. Schwartzmann (1961-64) all of Tucson, Southern District Directors. The Chairman further pointed out that Doctor Lindsay E. Beaton of Tucson, in addition to serving as a member of of the Board as Past President (1961-62), is also serving as the recently elected second delegate to the AMA for the years 1961 and 1962. The Association becoming a two delegate state effective January 1, 1961

Doctor Beaton placed in nomination the name of William B. Steen, M.D., Vice President to serve as Chairman of the Board for the ensuing fiscal year 1961-62, it being customary that the Vice President assume this position.

It was moved and unanimously carried that the nominations be closed, the Secretary declaring Doctor Steen unanimously elected Chairman of the Board for the ensuing fiscal year 1961-62, whereupon Doctor Steen assumed the Chair on relinquishing of the gavel by Doctor Yount.

ARMA House of Delegates – Resolution No. 6

Resolution No. 6 adopted by the House of Delegates of the Association in Annual Meeting held in Scottsdale, April 28, 1961, as amended: "to allow idstribution to be at the discretion and advice of the Central Office and the Board of Directors", referable to Resolutions No. 1 – Social Security and the Physician; No. 2 – Keogh-Simpson legislation and other voluntary retirement programs for the self-employed; No. 3 – all Federal legislation (e.g., Forand Bill, King-Anderson Bill (H.R. 4222) proposed health care under the social security system, and any other type of socialized medicine measure; No. 4 – voluntary health and accident insurance programs to cover the health and needs of our senior citizens and other segments of the population; and No. 5 – Kerr-Mills Bill and similar legislation to provide health care for the needy aged; each similarly adopted by the House of Delegates in Annual Meeting, Apirl 28, 1961, were presented for discussion and disposition as directed.

It was moved and unanimously carried that this matter be put in the hands of the Executive Committee for implementation and final disposition.

COMMITTEE MEMBERSHIP APPOINTMENTS

The following commitee appointments were made by the President, Leslie B. Smith, M.D., for approval by the Board of Directors in accordance with the By-Laws of this Association:

STANDING COMMITTEES

Benevolent and Loan Fund Committee

Doctor Donald K. Buffmire (Phoenix) (1959-62) was designated Chairman and Doctors Preston T. Brown (Phoenix) reappointed and Roland V. Murphy (Tucson) appointed members, each for the term 1961-64.

Doctors Arthur V. Dudley, Jr., Treasurer, (Tucson) – (specified); Doctor Paul L. Singer, Secretary, (Phoenix) – (specified); and Doctor Carl H. Gans (Morenci) (1960-63) complete the composite membership of the Benevolent and Loan Fund Committee.

Grievance Committee

Doctor Lindsay E. Beaton (Tucson-Pima), Past President, assumes the Chairmanship for 1961-62 (specified).

Doctor Francis M. Findlay (San Manuel-Pinal) and Doctor John F. Stanley (Yuma-Yuma) were appointed members of the Grievance Committee for the term 1961-64.

Doctor Carlos C. Craig (Phoenix-Maricopa) (1959-62); Doctor Oscar W. Thoeny (Phoenix-Maricopa) (1959-62); Doctor Hugh C. Thompson, Jr., (Tucson-Pima) (1960-63); and Doctor Florence B. Yount (Prescott-Yavapai) (1960-63) complete the composite membership of the Grievance Committee.

History and Obituaries Committee

Doctor John W. Kennedy (Phoenix) (1959-62) was designated Chairman, Doctor Howell S. Randolph (Phoenix) was reappointed and Doctor Edward M. Hayden were appointed members of the History and Obituaries Committee for the term 1961-64. Doctor Paul L. Singer, Secretary, (Phoenix) – (specified); Doctor Darwin W. Neubauer, Editor-in-Chief, (Tucson) – (specified); and Doctor Abe I. Podolsky (Yuma) (1960-63) complete the composite membership of the History and Obituaries Committee.

Industrial Relations Committee

Doctor John H. Ricker (Phoenix) (S-Hand) (1959-62) was designated Chairman; Doctor Charles P. Neumann (Tucson) (PN) was reappointed; and Doctor Oscar W. Friske (Ajo) (S-Ind) (1961-64) was appointed a member of the Industrial Relations Committee. Doctor John F. Curirn (Flagstaff) (Ca) (1959-62); Doctor Juan E. Fonseca (Tucson) (NS) (1960-63); and Doctor Robert W. Weber (Tucson) (Or) (1960-63) complete the composite membership of the Industrial Relations Commitee.

Legislative Committee

Doctor Derrill B. Manley (Phoenix) (1961-64) was appointed and designated Chairman; Doctor Jesse D. Hamer (Phoenix) was reappointed and designated Co-chairman; Doctor James E. O'Hare (Tucson); and Doctor Ben P. Frissell (Phoenix) were appointed members of the Legislative Committee for the term 1961-64.

Doctor John S. Carlson (Nogales) (1960-63); Doctor Paul B. Jarrett (Phoenix) (1960-63); Doctor W. Shaw McDaniel (Phoenix) (1959-62); Doctor William B. Steen (Tucson) (1960-63); Doctor George C. Truman (Mesa) (1959-62); and Doctor MacDonald Wood (Phoenix) (1959-62) complete the composite membership of the Legislative Committee.

It was further directed that the Legislative Committee use the current component county medical society presidents as an advisory body to the Legislative Committee (for the term 1961-62).

Medical Economics Committee

Doctor Ian M. Chesser (Tucson) (1961-64) was reappointed and designated Chairman; and Doctor John A. Eisenbeiss (Phoenix) (1961-64) was reappointed a member of the Medical Economics Committee.

Doctor Benjamin Herzberg (Phoenix) (1959-63); Doctor James E. O'Hare (Tucson) (1960-63); Doctor Donald A. Polson (Phoenix) (1960-63); and Doctor Paul L. Singer, Secretary, (Phoenix) (1959-62) complete the composite membership of the Medical Economics Committee.

Medico-Legal Committee

Doctor Wallace A. Reed (Phoenix) (1960-63) was designated Chairman; Doctor Jack E. Brooks (Phoenix) and Doctor George A. Spikes (Douglas) were appointed members of the Medico-Legal Committee for the term 1961-64.

Doctor Robert E. Hastings (Tucson) (1959-62); Doctor Louis Hirsch (Tucson) (1960-63); and Doctor Maurice Rosenthal (Phoenix) (1959-62) complete the composite membership of the Medico-Legal Committee.

Professional Committee

Doctor Robert B. Leonard (Phoenix) (S) (1961-64) was reappointed and designated Chairman; Doctor Ray Fife (Phoenix) (Or) (1961-64); and Doctor Howard W. Kimball (Phoenix) (GS) (1961-64) were reappointed members of the Professional Committee. Doctor James D. Alway (Phoenix) (Or) (1961-62); Doctor W. Albert Brewer (Phoenix) (S) (1961-64); Doctor Henry P. Limbacher (Tucson) (GS) (1961-63); Doctor George G. McKhann (Phoenix) (I) (1961-64); Doctor Herman S. Rhu (Tucson) (ObG) (1961-64); and Doctor Charles A. L. Stephens Tucson) (I) (1961-63) were appointed members of the Professional Committee.

Doctor Otto L. Bendheim (Phoenix) (PN) (1960-63); Doctor Orin J. Farness (Tucson) (I) (1959-62); Doctor Richard B. Johns (Phoenix) (Pd) (1959-62); Doctor Paul J. Slosser (Yuma) (GP) (1960-63); and Doctor Lowell C. Wormley (Phoenix) (GP) (1959-63) complete the composite membership of the Professional Committee.

Professional Liaison Committee

Doctor Ben P. Frissell (Phoenix) (I) (1959-62) was designated Chairman. Doctor Noel G. Smith (Phoenix) (GP) (1961-64) was reappointed; Doctor Clyde W. Kurtz (Phoenix) (U) (1961-64); Doctor Delbert L. Secrist (Tucson) (S) (1961-64); and Doctor Hugh H. Smith (Tucson) (PH) (1961-64) were appointed members of the Professional Liaison Committee.

Doctor Ernest A. Born (Prescott) (GP) (1960-63); Doctor Max Costin (Tucson) (ObG) (1960-63); Doctor William G. Payen (Tempe) (GP-ObG) (1959-62); Doctor Albert G. Wagner (Phoenix) (S) (1960-63); and Doctor Roy O. Young (Flagstaff) (ObG) (1959-62) complete the composite membership of the Professional Liaison Committee.

Public Relations Committee

Doctor Roland F. Schoen (Casa Grande) (1960-63) was designated Chairman. Doctor Robert H. Bullington (Phoenix); Doctor Charles H. Finney (Phoenix); Doctor Fred L. Goff (Douglas) Doctor Ralph T. Irwin (Yuma); Doctor John F. Kahle (Flagstaff); Doctor J. Edwin Keppel (Mesa); and Doctor Clarence L. Robbins (Tucson) were appointed members for the term 1961-64.

Doctor Howard W. Finke (Superior) (1960-62); Doctor Paul B. Jarrett (Phoenix) (1959-62); Doctor Clarence H. Kuhlman (Tucson) (1960-63); Doctor W. R. Manning (Tucson) (1959-61); and Doctor Leo L. Tuveson (Phoenix) (1960-63) complete the composite membership of the Public Relations Committee.

Publishing Committee

Doctor Darwin W. Neubauer, Editor-in-Chief, was designated Chairman for the 1961-62 term (specified). Doctor Clarence L. Robbins was reappointed as member for the term 1961-64.

Doctor R. Lee Foster (Phoenix) (1959-62); and Doctor John R. Green (Phoenix) (1960-63) complete the composite membership of the Publishing Committee.

Scientific Assembly Committee

Doctor Richard O. Flynn (Tempe) was designated Chairman and Doctor Clarence E. Yount, Jr., (Prescott), President-elect, was designated as Co-chairman for the term 1961-62.

The following members recommended were appointed on a staggered three-year term basis in accordance with By-Laws amendment adopted April 28, 1961, the Scientific Assembly Committee to give consideration and stipulate the terms on a staggered basis: Doctor James E. Brady, Jr., (Tucson) (Southern) (GP); Doctor Richard E. H. Duisberg (Phoenix) (Central) (PN); Doctor Richard O. Flynn (Tempe) (Central) (GP); Doctor Fred L. Goff (Douglas) Southeastern) (GP); Doctor David C. James (Phoenix) (Central) (GS); Doctor Richard B. Johns (Phoenix) (Central) (Pd); Doctor Fred H. Landeen (Tucson) (Southern) (Anes); Doctor William H. Lyle (Yuma) (Southwestern) (GP); Doctor Darwin W. Neubauer (Tucson) (Southern) (S); Doctor Walter M. O'Brien (Globe) (Northeastern) (GP); Doctor Edward Sattenspiel (Phoenix) (Central) (ObG); Doctor Roland F. Schoen (Casa Grande) (Southwestern) (S-GP); Doctor John R. Schwartzmann (Tucson) (Southern) (Or); and Doctor William B. Steen (Tucson) (Southern) (I-A).

SPECIAL COMMITTEES

Articles of Incorporation and By-Laws Committee

Doctor Paul B. Jarrett (Phoenix) was reappointed and designated Chairman; Paul L. Singer, Secretary, (Phoenix) was reappointed; Doctor Walter Brazie (Kingman) and Doctor Frank A. Shellenberger (Tucson) were all appointed

members of the Articles of Incorporation and By-Laws Committee for the term 1961-62.

Central Office Advisory Committee

Doctor Arthur V. Dudley, Jr., Treasurer, (Tucson) was appointed and designated Chairman; Doctor Paul Singer, Secretary, (Phoenix) and Doctor William B. Steen, Vice President, (Tucson) were appointed members of the Central Ofifce Advisory Committee for the term 1961-62.

Executive Committee

Doctor Leslie B. Smith, President, (Phoenix) was designated Chairman; Doctor Clarence E. Yount, Jr., President-elect, (Prescott); Doctor William B. Steen, Vice President, (Tucson); Doctor Paul L. Singer, Secretary, (Phoenix); and Doctor Arthur V. Dudley, Jr., Treasurer, (Tucson) constitute the Executive Committee for the term 1961-62.

Medical School Committee

Doctor W. Albert Brewer (Phoenix) was reappointed and designated Chairman; Doctor Lindsay E. Beaton (Tucson); Doctor W. R. Manning (Tucson); Doctor Dermont W. Melick (Phoenix); and Doctor Clarence L. Robbins (Tucson) were all reappointed members of the Medical School Committee for the term 1961-62.

Procurement and Assignment Committee

Reactivated is the Procurement and Assignment Committee. Doctor Joseph M. Greer (Phoenix) (Central) (Retired) (1961-62) was appointed and designated Chairman; Doctor Robert N. Class (Tucson) (Southern) (I); Doctor John F. Currin (Flagstaff) (Northwestern) (I); Doctor Ruland W. Hussong (Phoenix) (Central) (GP-ObG); Doctor Robert M. Matts (Yuma) (Southwestern) (GP); and Doctor Joseph P. McNally (Prescott) (Northwestern) (GP)) wer appointed to the Procurement and Assignment Committee for the term 1961-62.

It was moved and unanimously carried that these appointments to both Standing and Special Committees as presented by the President be approved and confirmed by the Board of Directors.

MEETING ADJOURNED AT 6:15 P.M.

Paul L. Singer, M.D.
Secretary

AD HOC MINISTERIAL LIAISON COMMITTEE

The first meeting of the Ministerial Liaison Committee was held on 4-21-61. Those attending the meeting were:

Dr. Glen McGee, Reverend Powell Green, Reverend Charles S. Schmitz, Reverend Elliot Luther, Reverend Lewis S. Eaton, Derrill B. Manley, M.D., James D. Barger, M.D., Leo L. Tuvesom, M.D., Philip G. Derickson, M.D.

The meeting was opened by a prayer by Reverend Charles E. Schmitz. That section of the Arizona Revised Statutes pertaining to marital and domestic relations Title 25, Chapter 1, Section 25-103.01 was read, and it was noted that the following wording is used: "Certificate shall state that the applicant has been given such examination, including a standard serological test, as may be necessary for the discovery of syphillis." The minutes of the meeting of the Executive Committee of the Arizona Medical Association, Inc., held 10-22-60 in reference to the interview with members of the Arizona Council of Churches was also read. An editorial "The Premarital Examination" was then read from the January-February 1961 issue of Hawaii Medical Journal.

Dr. James Barger then discussed the historical background regarding the objection on the part of some members of the Maricopa Medical Society, particularly the pathologists, when the initiative measure was proposed in 1956. The objections which have been put forth recently regarding the facts that the standard serological tests rarely reveal infectious syphillis, that many of the positive reactions are false, that there are better methods of case finding than pre-marital serological tests were brought out at that time. A review of the transcript of the House of Delegates meeting held on 4-26-56 and the resolution presented and adopted by the House of Delegates on 4-25-56 shows no evidence of objection by any doctors present at that meeting. Dr. Barger continued with the historical background, stating that the measure became law and that most of the objectors have remained quiet. A general discussion regarding serological testing for syphilis was then led by Dr. Barger in which it was pointed out that in testing the hospital

population, one to two per cent revealed a positive serological testing. He estimated that one-half of these positive serological tests were positive for syphilis. The other half were false positive.

It was generally agreed that for the purpose of any further discussion of this subject, findings should be obtained from the State Department of Health regarding any possible changes which have taken place since this law became effective and whether there has been any significant increase in the reported incidence of syphilis, etc. Dr. Barger pointed out that a state law requires that every pregnant woman must have a standard serological test prior to delivery of each baby, thus partially answering the criticism that a negative standard serological test at the time of applying for a marriage license perhaps would not reveal a recent infection with syphilis which could be transmitted to a child subsequent to the marriage. It was also pointed out that there has been no criticism of the law requiring a standard serological test for a pregnant woman, although it would appear that those criticisms which have been leveled at the pre-marital examination standard serological test would hold in either case.

Dr. Barger summarized his report by pointing out that the diagnosis of syphilis is not based on a laboratory test, but is rather the result of a physical examination. In reviewing the wording of the statute, it is noted that the law calls for "such *examination*, including a serological test, as may be necessary for the discovery of syphilis."

It was generally agreed by all members present that the law requires a physical examination, admittedly limited to the search for evidence of syphilis, but definitely an examination of the person and not solely the standard serological test. The Reverend Mr. Schmitz commented that he was chairman of the conference sponsoring this measure, and that he knew of some opposition to the measure on the part of pathologists particularly, at the time, and was surprised that the Medical Association backed the measure without reservation. He expressed the view as being the consensus of all ministers that the waiting period certainly should be preserved, and deferred the matter of the serology to the medical profession.

The Reverend Mr. Green commented that the waiting period is of advantage, and praised the initiative measure because of the opportunity it gives for counselling, particularly since the applicants for marriage are referred to a physician who is in a position to counsel in much the same way as the minister.

The Reverend Mr. Eaton reviewed his plan of counselling with married couples and indicated that one of his points of advice is that the couple select a family physician and arrange separate appointments so that the doctor can perform a physical examination prior to their marriage.

Dr. Glen McGee expressed the opinion that the present law and the serological test may not be fully adequate, but they represent the most adequate means we have at the present time under the law for this purpose. He also revealed that he has heard no serious obtections to this law from any of the couples that he has counseled. He expressed a desire for more help from physicians on counselling couples anticipating marriage and he believes that this is a field in which the physicians could be much more effective with more time and effort. He acknowledged that many physicians are now carrying out pre-marital counselling along with their physical examination, but expressed the hope that this degree of excellence would be more wide spread.

After further discussion of the status of the present statute it was moved by Doctor Barger that this committee submit a recommendation to the Arizona Medical Association that no change be made in the law. The motion was seconded and passed unanimously.

The ministers attending the meeting expressed a desire for more rapport between the physician and the theologians regarding treatment of the whole person. Several proposals were made informally regarding the possibility of having a state wide meeting of ministers and doctors for the purpose of education and study of problems common to the two groups. The second proposal was for local groups of doctors and ministers to discuss their common grounds in their communities, rather than to start out on a state wide basis.

Dr. Manley indicated that it was his belief that physicians would respond to such a meeting if the connection between the doctors and the theologians would be clearly adopted to medicine rather than basing the meeting on the "no

man's land of emotional and spiritual problems."

In summary, it is the consensus of the Ministerial Liaison Committee that the present statute should not be repealed, but that the physicians of the state should be advised of the interpretation of the wording "such examination, including a standard serological test, as may be necessary for the discovery of syphilis." This will require that each applicant for marriage will have a physical examination, admittedly limited, but adequate for the discovery of syphilis. The statute clearly indicates that merely the obtaining of a standard serological test is not the meaning of the law. In the light of this interpretation, we believe that the statute is not objectionable, and recommend no change.

Respectfully submitted

Philip G. Derickson, M.D., Chairman
Ad Hoc Ministerial Liaison Committee
Arizona Medical Association, Inc.

ON AGING

PLUS CA CHANGE, PLUS C'EST LA MEME CHOSE

The world changes. The solutions to problems alter but the questions do not. Population expands at an explosive rate and we who are practicing medicine are in large degree responsible for this explosion at either end of the age scale. It behooves us, thus, to concern ourselves intimately with all details of the explosion for which we are in a fundamental sense responsible.

The world changes. The primitive Eskimo answers the problems of the aging by leading willingly into the storm and the cold the aged and the infirm who are no longer able to contribute their share to the upkeep of the community. In an earlier and simpler civilization in our own country, the aged were cared for in the houses which they had built with the strength of their hands on the land which they had tilled with the love of their hearts, bound in a sense to a common destiny to those who were younger than they by the love of the land and the love of the home.

The world changes, but the questions remain. When our civilization moved from an agricultural to a more industrial society, the provision for those who were growing older and who were less productive was first sought in Time. Plans of one sort or another including, ultimately, old age and survivor's insurance, established an arbitrary date in life at which an individual was considered to have entered a golden era in which he might walk quietly and placidly down the road to oblivion. It is evident that this technique ignores a fundamental change in the status of the aging which we who practice medicine have introduced into our modern civilization, namely that the aging constitute no special group of necessity infirm and incompetent, but only a certain number of individuals of taste and attitudes modified but little through the experience of living. The American Medical Association in its recent reports on the subject of aging has carefully stressed the fact that there are per se no diseases *of* the aged, but only diseases *in* the aged. Concurrent studies done elsewhere tend to indicate too, that the aged, in their psychosomatic attitudes, preserve fundamental concepts to the end of their days that were present throughout all their lives. From this it is fairly apparent that the problems which exist relative to the aged and aging are problems which in large degree are artificially foisted upon them and engendered by the rules and regulations of our society.

As doctors we must concern ourselves with several aspects of the problem of aging. First and foremost, of course, we are charged with adequate care of the physical health needs of those individuals who have passed beyond the prime of life. Additionally throughout all its career medicine has sought to give care to all those who require it, without compensation if need be, or for such compensation as the individual can afford. With the complexity of modern diagnostic and therapeutic regimens, however, it is not enough for the physician himself to offer his care to an individual on a free or a part-pay basis since much of the control of the diagnostic and therapeutic means requisite to the total care of a patient is no longer in the hands of the individual practitioner. Numerous means of avoidance of this dilemma have been sought. The most recent of these is an effort to impose upon the aging population a compulsory type of health insurance through the offices of the social security system. In our own state the approach is unrealistic; fully 50% of the aged within our state have no social security coverage. Of the

remaining 50% who are so covered, it is dubious that even a significant percentage is in need of government help in defraying medical expense. A recent hospital survey conducted in southern Arizona tends to indicate that probably more than 90% of all individuals over 65 years of age requiring hospitalization were able to finance the cost of this hospitalization either by themselves, through savings, through insurance, or through the assistance of immediate relatives. In our conscience, as physicians, however, the knowledge that even 10% are incapable of meeting their basic requirements, should be too much. Voluntary health plans are expanding apace. They have shown themselves in large degree capable of meeting the requirements of younger individuals, and if we bear in mind the studies of the American Medical Association previously referred to, we must reach the inevitable conclusion that since there are no special diseases of the aged and the aging, so there can be really no special problems of the aged and the aging that cannot be met by modifications of answers given to problems existing in younger age groups. In this regard, a plan is now under study suggesting the feasibility of coverage for those individuals who are unable to care for themselves by their own efforts alone through voluntary insurance plans by state participation in and state coverage of them in private insurance organizations. For the preservation of the dignity of these individuals, it is devoutly to be hoped that some plan will also be formulated whereby from each according to his ability some contribution toward his insurance may be obtained.

"The preservation of his dignity"! — "Aye, there's the rub!" There are too many of us who have reached the age of 65 who are compelled by law or custom to cast ourselves upon the funeral pyre of uselessness. One answer that has been suggested to the problem of the preservation of human dignity is such persons as are retired (whether by compulsion or choice) has been to suggest that all individuals should be regarded as in the same category, all should be covered alike by a paternalistic government with its arms enfolding them in a cradled grave of protectiveness, so that those who are rich and require none of it and those who are poor and require it all shall appear alike in the eyes of the people of our country. One can question whether this is a truly American method of preserving dignity; a basic principle of our governmental philosophy has been that each individual shall be given an equal opportunity to fend for himself; it by no means provides for the fact that all men should be equal in their ability. As our nation approaches a welfare state organization, there is a tendency to downgrade all individuals, the competent to the grade of the incompetent and these left at their original level so that all alike shall be assigned to a comparable grade of unproductiveness when they have reached a given number of calendar years. I submit this is not the preservation of human dignity.

A second phase, then, with which the physician in the United States must concern himself insofar as the problems of aging are concerned, is the preservation of human dignity as the human being himself would see it. The Declaration of Independence regards as among the inalienable rights of man the rights to life, liberty and the pursuit of happiness. Life and liberty, to be sure, are statutes not revoked from those who are older than 65; but is the pursuit of happiness a route which is prescribed by law? It is sincerely to be hoped that the Arizona Medical Association will concern itself with this third right of man. It is imperative that ways be found and means devised whereby the older citizens of our state may render themselves useful not only economically to the populace as a whole, but economically and psychologically to themselves as well. It is fitting and proper that the infirm be aided where they are unable to aid themselves; it is merciful and humane that the incompetent be not destroyed as the result of their incompetence; it is equally humane that the competent and the firm, irrespective of age group, should not be sacrificed upon the altar of an inflexible calendar. To this end, we as doctors must concern ourselves with the psychological well being of our patients as well as their physical status. Every move must be made to find gainful occupations in which those of older years can engage with a preservation of dignity and an improvement in economic security for those who require it.

Specific recommendations may be made in these regards: the possibility of hospitalization and medical insurance under the Blue Cross — Blue Shield plans, or any comparable plan, should be broadened insofar as possible to cover the medical needs of all citizens, irrespective of

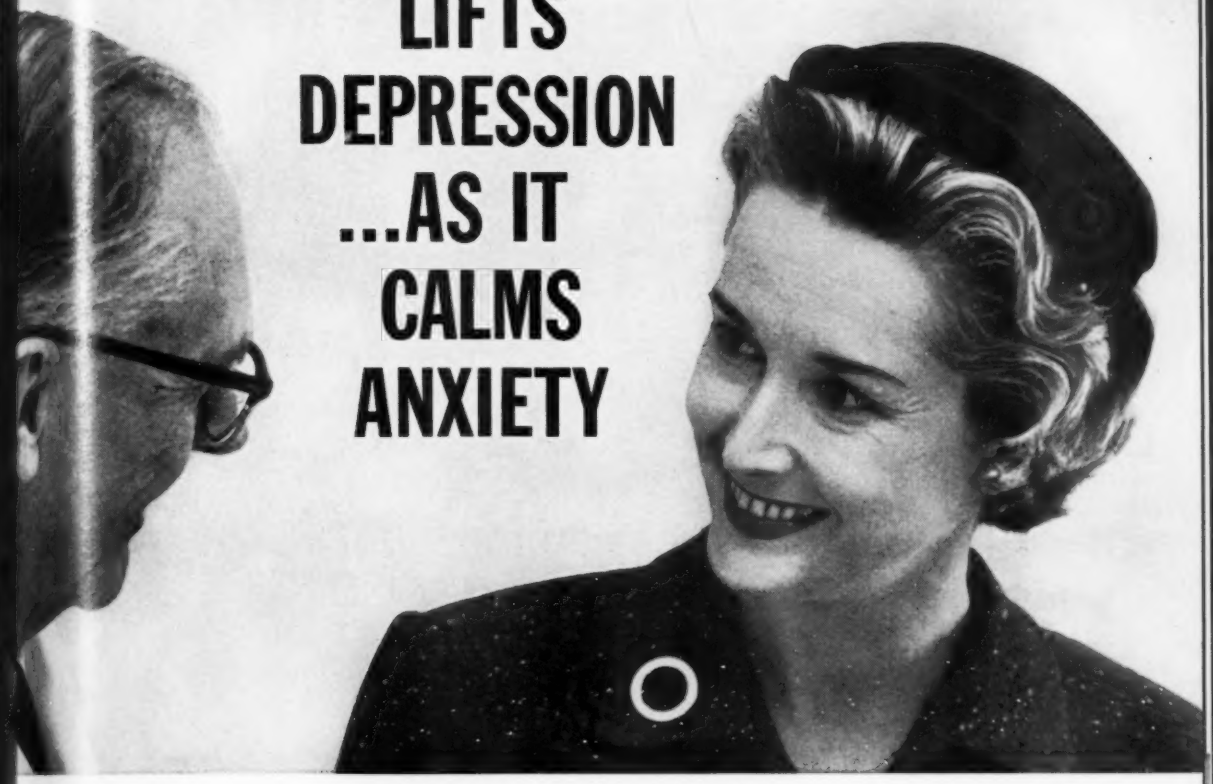
age. In the instances of those individuals who are county or state charges, the state by right and by necessity should contribute its share, up to 100% if necessary, of the premiums required for the coverage of such individuals. The remuneration by the participating insurance company or companies to the agencies providing the care should most properly be scaled to the minimum. This downscaling of costs could properly include not only the fees offered the attending physician, but the costs of hospitalization, prosthetic devices whether dental or orthopedic, glasses, drugs, and in fact, all of the medical and health requirements of these individuals properly covered by insurance. Such a plan appears both economically feasible and feasible from an acturial viewpoint. A plan of this sort is currently under study within this state and is currently operational in Colorado.

Thus we endeavor to encompass the entire question not only of aging but of medical and economic care for our entire population. Those who can do so and wish to do so should be permitted to care for themselves as has been traditional within our society since its inception. Those who can do so only in part should be aided and assisted by those who are better able to carry the burden; and those who are unable to care for themselves in whatever manner must be assisted totally from the outside. And it must be recalled that from the point of view not only of society at large but of the individuals involved as well, – the aging, – it is not only morally but probably economically as well unsound to regard them as a special group with special problems.

Samuel J. Grauman, M.D.

Report filed with the Professional Committee of the Arizona Medical Association, Inc., at its meeting March 12, 1961.

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



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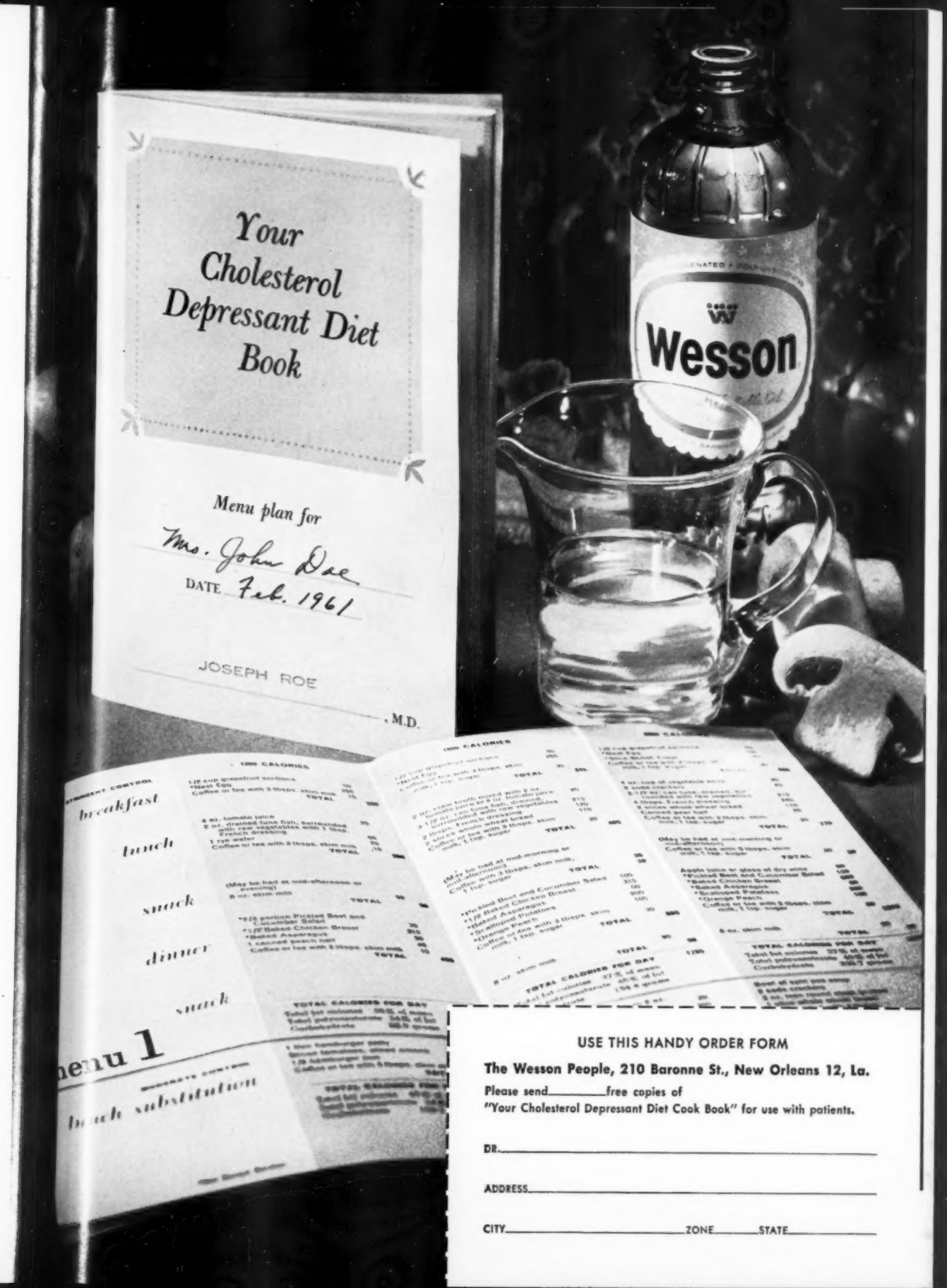

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Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.
Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, a few cases of [illegible] penia and agranulocytosis have been reported [illegible] patients treated with Albamycin. Most of these side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow [illegible] pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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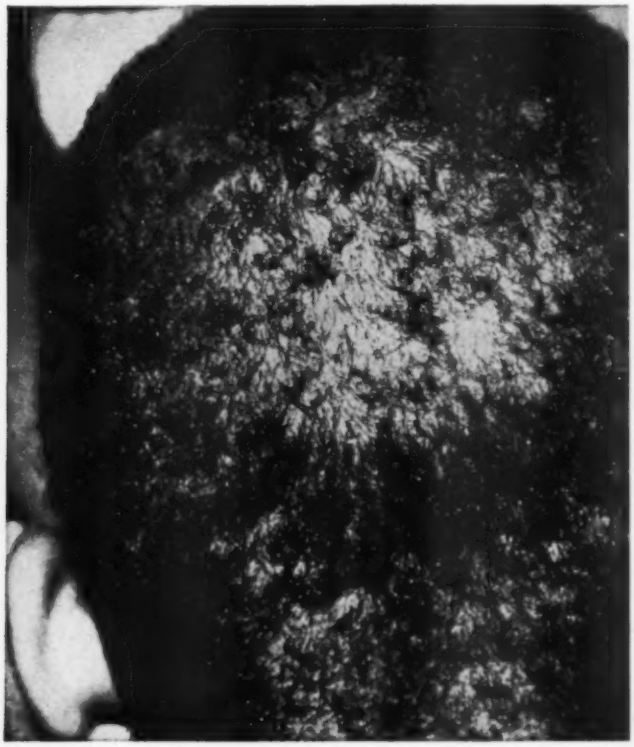


*New Product Announcement

Vol. 18, No. 7 July, 1961

Recent Trends in Medical Economics
—HISTORY AND PROPHECY

Russell V. Lee, M.D.

This challenging article presents the opinion and counsel of an outstanding thinker in American medicine. The author is properly identified with Alan Gregg's "Great Medicine," yet he has worked for the most part outside the cloister of ivory towers. Dr. Russel V. Lee is founder and director of the Palo Alto Medical Clinic, one of the most successful ventures in group practice in the United States.

THE INTEREST – and it is intense – in medical economics is occasioned by a simple but fundamental fact – medical services are worth having. It has not always been so. In 1910 it was said, probably truly, that the random patient with the random disease making a random contact with a physician stood less than a fifty per cent chance of profiting by the encounter. Not so now. The astounding progress of the science of medicine in thirty years has made it demonstrably evident that freedom from unnecessary suffering and premature death can be purchased if the client has the means and access to medical care of high quality. Health can be purchased. People know this. Labor leaders know this. Politicians know this too, and prepaid medical care is now replacing "bread and circuses" as the bait for votes, with the result that practically every large country has socialized medicine so firmly established that it will never be abandoned.

When the physician was quite aware of the probable inefficacy of his cures, he left the fee up to the largess of his patient. But later, when he had something to sell which was attractive, particularly the dramatic operation made possible by asepsis and anaesthesia, he charged what the traffic would bear. But because, in spite of the life-saving nature of some of his procedures, in the aggregate it really mattered little whether one had a physician's services or not, denial of access to such services was not sociologically a very important thing. But now, when it is well known that one's children survive or perish in proportion to the quality of medical care available, when death in childhood is becoming extremely rare in good hands, it is intolerable to people that such services are denied them because of an economic barrier. A new principle, unthinkable fifty years ago, now prevails. It is that access to medical care of high quality is a human right which must not be denied to anyone. And as a corollary to this concept is the second – that the state must provide it if the individual cannot.

Now this has come about at a time when as a result of a long trend, beginning with the Flexner Report in 1910, the relative number of trained medical personnel in relation to a burgeoning population has dropped. The demand

Presented before the Pima County Medical Society, Tucson, Arizona, October 11, 1960.
Palo Alto Medical Clinic, Palo Alto, California.

has increased, is increasing, and will increase still more, and the supply lags. One must appreciate these basic facts to understand why socialized medicine has come to so many countries, why medical insurance which covered in some measure perhaps 2,000,000 people in 1938 covers 130,000,000 today. And why with increased life expectancy, medical care for the aging becomes such a hot political issue today.

What has been done to meet the situation and what is likely in the years to come are certainly important questions, but not easy ones to answer. The answer to the first question cannot be covered by one word for various things have been done by various people with varying points of view. The doctors were and are not unaware of the situation and in the creation of the "Blues" — Cross and Shield — have contributed greatly to one solution. The commercial insurance companies, loath to enter the field two decades ago, are in it now to a multi-billion dollar extent. The labor unions never accept an agreement without a health and hospital clause and sometimes buy the services, with many furnished by the employers and sometimes, as in the case of the mine workers, they provide their own hospitals and doctors to supply the need. The clients have organized cooperatives which either buy services or, in the case of some like Puget Sound, set up their own services. The government spends a billion dollars a year to provide services for the veterans and now adds dependents of military personnel to the beneficiaries. Many insurance plans are sold on the basis of experience rating to a great extent and thereby exclude many who need the services the most urgently. The closed panels excite hostility on the part of organized medicine and have trouble getting doctors. The cooperatives suffer from lack of administrative skill and experience in a very technical field. The government services suffer from the pressures of the "gimme" boys and the tendency of all governmental agencies to abnormal hypertrophy. To be sure much, very much, of great value has been achieved, but none of the systems is entirely satisfactory.

Out of the welter, certain unmistakable trends can be seen. One of these is the remarkable growth of group practice as an acceptable, and increasingly accepted, way of medical life. Dr. Pomrinse, of the United States Public Health Service, has just completed a survey that shows at least a three-fold increase in the number of groups since the last survey in 1946. The group is perhaps the best presently available answer to the shortage of medical personnel. There are certainly great economies to be achieved under group practice and, because of the ability of the group to use paramedical personnel to such a great degree, the number of patients who can be cared for by each doctor is greatly increased. And, furthermore, the group provides the only possible mechanism for the provision of comprehensive medical services from the physician to the client without the intervention of any third party. To be able to do this saves greatly in money and, by obviating the burdensome mountain of reports, saves the doctor's time and disposition. This system, by direct prepayment between a group of patients and a group of doctors, seems destined to grow and certainly has many advantages for both patient and doctor.

To be sure, only between fifteen and twenty per cent of physicians are in group practice and hence there are great limitations on the possible growth of such systems. However, a situation has developed in the last twenty years that curiously provides a ready-made mechanism for a great extension of this highly desirable development. This is the institution of the modern hospital and the hospital staff. The staff of a modern hospital partakes of many of the characteristics of a proper group. It usually encompasses a wide spectrum of skills which includes all the usual specialties. The members are subject to a certain selection before achieving staff status and a very real discipline over competence and quality of care rendered. The economic problems of converting a hospital staff to a group providing prepaid care is not very difficult of solution. Most well-qualified doctors do belong to some hospital staff and hence freedom for the patient to receive his care from the physician of his choice can be assured.

Here then is a pattern for the future if we are to escape socialized medicine in this country. Let us have direct, comprehensive prepayment between the people, on the one side, and the hospital and the hospital staff on the other. The two services, hospital and physicians services, should be completely separated. Let every person, young and old, good risk and poor, be admitted

o the plan. They all should belong to a hospital ssociation which they – the customers – control in regard to how much hospital benefit they vant to pay for. If longer stays in the hospital nd more ancillary services, such as drugs, etc., re desired, higher dues must be levied. Let the ospital staff undertake to furnish these people vith medical, i.e., physicians' services on a comprehensive, no-exclusions basis for an agreed apitation fee. Let the staff itself decide on the livision among the doctors rendering the service. A development and refinement of the well-ried "unit" system would probably be most satsfactory. Outpatient services should be included and the aged should be bracketed in with the young.

This is a plan which could be implemented forthwith wherever there is a hospital with a hospital staff. It will give the patients what they want by comprehensive care on a prepaid basis with freedom of choice within the hospital staff as to which doctor they prefer. It will keep the third party with his big "bite" out of the picture and, hence, more service can be given or lower fees charged. It will keep the control of rates and method of physicians' reimbursement in the hands of the physicians themselves where they belong. It is the most feasible presently available alternative to socialized medicine.

Neoplasms among A-bomb survivors in Hiroshima: first report of the research committee on tumor statistics, Hiroshima City Medical Association, Hiroshima, Japan.

Tomin Harada, M.D., and Morihiro Ishida, M.D. Hiroshima City Medical Association and Atomic Bomb Casualty Commission, National Institute of Health, Hiroshima, Japan. J. Nat. Cancer Inst. 25: 1253-1264, 1960.

Summary

The 1957-58 incidence of neoplasms among the survivors of the Hiroshima A-bomb varies directly with radiation dose, insofar as it may be inferred from distance from the hypocenter at exposure. The incidence of all malignant neoplasms among the survivors who were within 1000 meters is more than four times that of the nonexposed population. The incidence of benign neoplasms among the survivors exposed within 1500 meters is also significantly higher than that among the nonexposed. For survivors under 1500 meters there are significant differences between the number of observed cancers of the lung, stomach, uterus, and ovary and the expected cases calculated from the age-specific rates of the nonexposed portion of the Hiroshima population. The increased incidence among survivors within 1500 meters is not related to sex or age.

– National Cancer Institute, National Institutes of Health, Bethesda, Maryland

Where Can Coccidiodomycosis Be Acquired in Arizona?

Keith T. Maddy, D.V.M., M.P.H.
H. Gilbert Crecelius, Ph.D.
Richard G. Cornell, Ph.D.

A total of over 11,000 home-raised cattle one to six years of age in selected areas over the State of Arizona were given skin tests with coccidioidin. Some 2,859 (24.6%) of these cattle were found to be positive. The annual conversion rates for cattle were found to be almost identical with the actual human infection rates per year in those counties in which this relationship was studied. These skin tests in cattle were found to give a fairly accurate prediction of the incidence and prevalence of human infections in the same areas.

This investigation was supported in part by a research grant (Number E-1392) from the National Institutes of Health, Public Health Service. The study which defined the specificity of the test used in this study was supported by a grant by the Arizona Tuberculosis and Health Association and its affiliates.

Dr. Maddy is a Veterinary Officer of the U. S. Public Health Service and is now in Washington, D. C. in the Laboratory of Medical and Biological Sciences of the Division of Air Pollution. At the time of this study he was with the Communicable Disease Center of the U. S. Public Health Service in Atlanta, Georgia and assigned to the Arizona State Department of Health. Dr. Cornell, at the time of this study, was a Statistician with the Communicable Disease Center and now is Associate Professor of Statistics, Florida State University, Talahassee, Florida. Dr. Crecelius is Director of the Division of Laboratories, Arizona State Department of Health.

This article is based in part on a paper given at a Conference of the Epidemic Intelligence Service, Communicable Disease Center, in Atlanta, Georgia, on April 16, 1959.

INTRODUCTION

WHERE CAN coccidioidomycosis be acquired in Arizona? What is the relative risk of infection with the fungus *Coccidioides immitis* in any given place in Arizona? These are questions which have been asked by physicians, veterinarians, and other workers in medical, public health and related fields since the time that Wooley(1) first discovered 23 years ago that the infection could be acquired within the State.

Geographic distribution of *Coccidioides immitis* in Arizona has been determined previously by noting the areas of the State in which cases of coccidioidomycosis in humans are reported (1-10); by several skin test surveys conducted on various population groups (10-17) (Figures 1 and 2) and by trapping rodents in specific geographic areas and examining them for the presence of *C. immitis*. (18).

Skin test studies on man, however, have all had shortcomings which make pinpointing the infectivity of a small area difficult. In some instances large areas with little population were not surveyed. Many persons who migrate to Arizona from the Midwest have been previously in-

GEOGRAPHIC PATTERN OF COCCIDIOIDIN SENSITIVITY IN WHITE PERSONS 17-21 YEARS OF AGE WHO HAD BEEN LIFETIME ONE-COUNTY RESIDENTS IN ARIZONA

Study by: PALMER, EDWARDS, and ALLFATHER (1957)

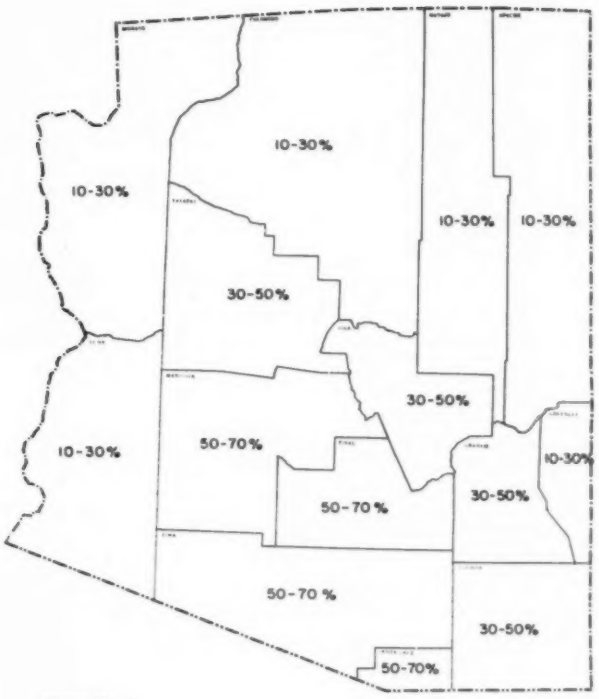


Figure No. 1

Study by: MADDY, DOTO, FURCOLOW, LEHAN, RUBIN, GREENE, CASPER, and COLEMAN (1957)

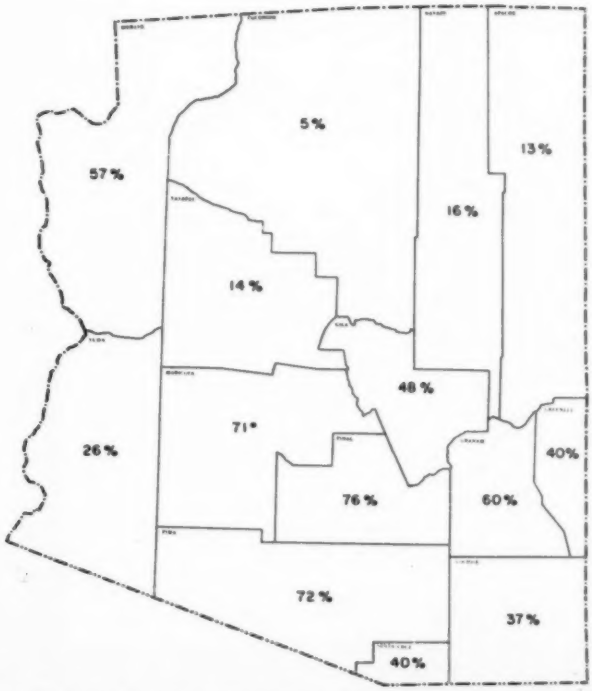


Figure 2. Geogfraphic Pattern of Coccidioidin Sensitivity in 955 High School and College Students who had spent 80% of their Lifetimes in Arizona.

fected with *Histoplasma capsulatum*, a potential cause of a cross reaction to the coccidioidin skin test. Also, persons living in the State travel about a great deal both inside and outside Arizona.

Although only a few studies of coccidioidin skin tests in animals have been reported, (19,20) it has been shown that cattle within the more obviously endemic areas become infected and react to skin tests (Figures 3, 4, and 5). This study was undertaken to determine more definitely the extent of the endemic areas and to map the relative infectivity in various parts of Arizona.

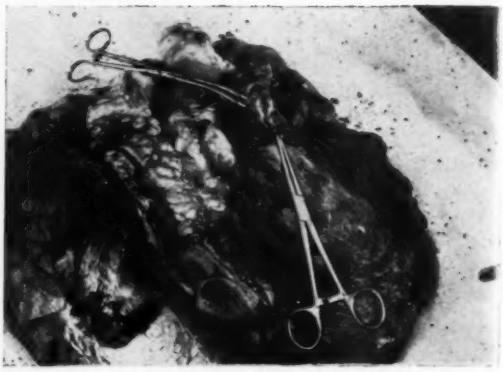


Figure 3. A Cow's Lung with Instruments Holding Open a Coccidioidal Granuloma. Note Pulmonary Lymph Nodes just to the left that are Enlarged and are Cut Open to Show Internal Granulomas.

MATERIALS AND METHODS

Between 1954 and 1959, 11,643 cattle were coccidioidin skin tested in the 14 counties of Arizona. The cattle were selected at random in various parts of each county. Few of these animals had been more than several thousand feet from where they were born. Their ages to the nearest year ranged from 1 through 6.

Lot 15087 of coccidioidin was used early in the survey and later Lot 59-62 was used. It was standardized to the same sensitivity as Lot 15087 by simultaneously testing cattle with both skin test agents and then concentrating the 59-62 behind a collodion filter until the skin test agents gave identical results. Both lots were furnished by Dr. C. E. Smith of the University of California at Berkeley.

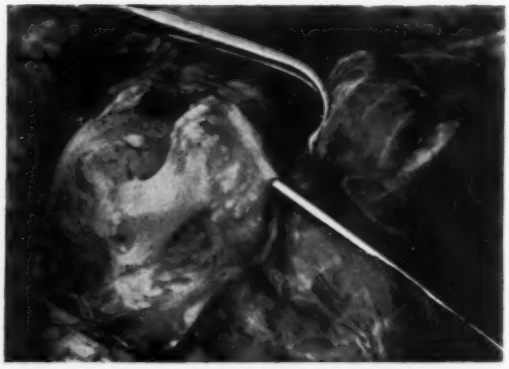


Figure 4. A Close Up of Two Opened Coccidioidal Granulomas in a Bovine Lung. The Bovine in the Endemic Area Becomes Infected Often Without Grossly Palpable Lesions Like These in the Lung, but Almost Always at Least with Grossly Visible Lesions in the Pulmonary Lymph Nodes. Almost all Lesions Heal Completely in a Few Weeks After Infection.

The specificity of undiluted Lot 59-62 in detecting cattle experimentally infected with *C. Immitis* had been reported(21). Several other preliminary experiments were carried out on naturally infected cattle in the endemic area to arrive at a standard testing procedure. They are summarized briefly here.

Each of 181 cattle was injected intradermally with undiluted and with 1-2, 1-5, 1-10, and 1-100 dilutions of coccidioidin. All animals that reacted positively (indurations of over 5 mm.) to diluted skin test agents also reacted to the same agent when it was used in a more concentrated form. The reverse was often not the case, that is, an animal might react to a concentrated agent but fail to react to a more dilute solution of it. To the undiluted, 135 reacted, 121 reacted to

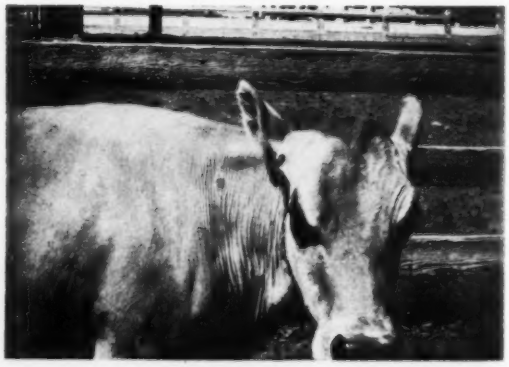
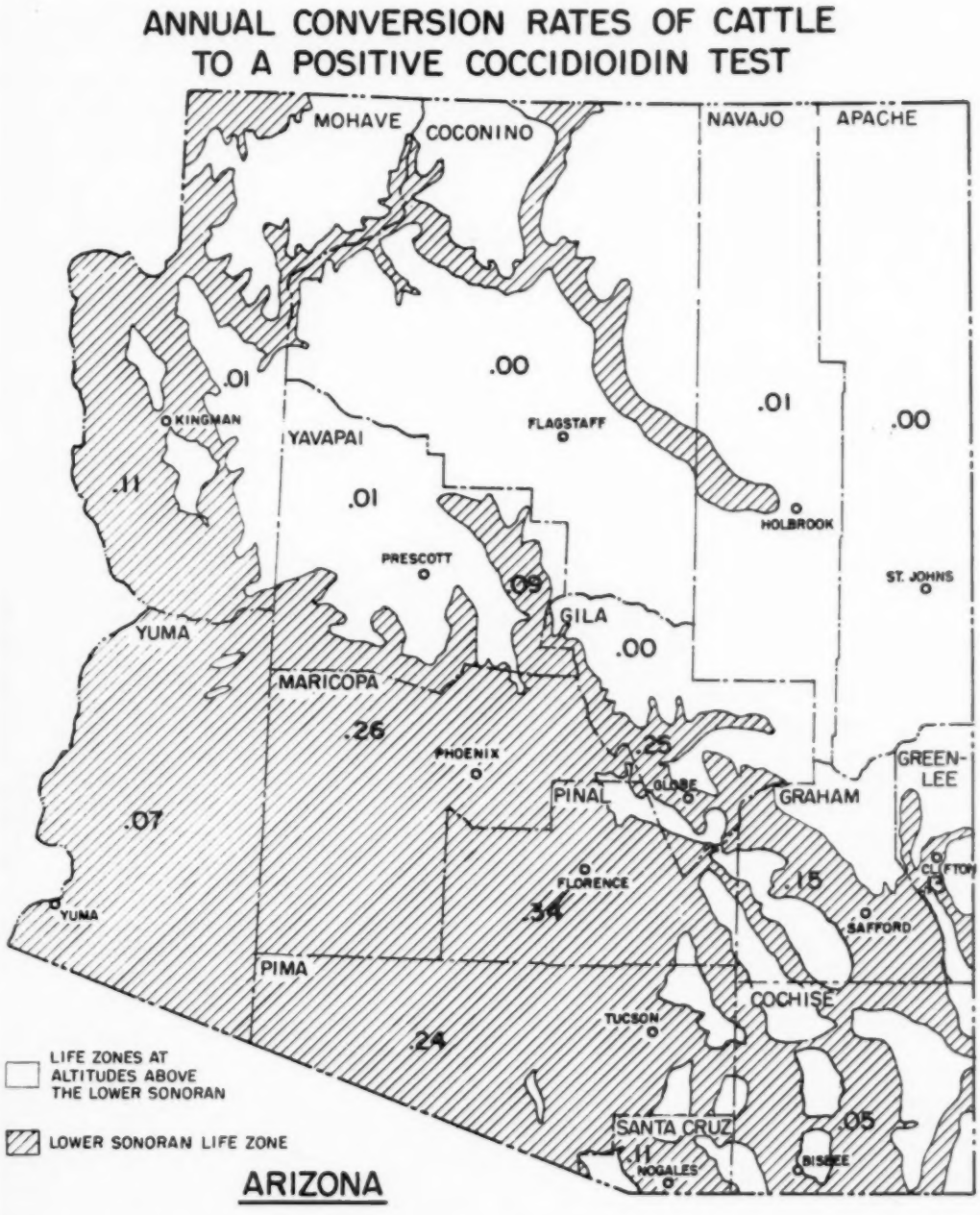


Figure 5. A Positive Coccidioidin Test on a Cow's Neck 96 Hours After Injection.



A TOTAL OF 11,643 CATTLE WERE TESTED ON RANCHES SCATTERED THROUGHOUT EACH COUNTY AND ONLY CATTLE THAT HAD SPENT THEIR ENTIRE LIFETIMES ON THE RANCH WHERE BORN WERE TESTED. FOR MOHAVE, YAVAPAI, AND GILA COUNTIES, TWO FIGURES ARE GIVEN. ONE IS FOR ALL TESTS WITHIN THE LOWER SONORAN LIFE ZONE. THE OTHER FIGURE IS FOR ALL TESTS ABOVE THE LOWER SONORAN LIFE ZONE. ALL THE TESTS IN GREENLEE COUNTY WERE IN THE LOWER SONORAN LIFE ZONE. ALL THE TESTS IN COCONINO COUNTY WERE IN ZONES ABOVE THE LOWER SONORAN LIFE ZONE.

Figure 7. This Map When Converted to Human Use Indicates by Counties or Parts of Counties the Proportion of the Susceptible Human Population Which Would Convert to a Positive Coccidioidin Test Within a Year's Time if the People Stayed Permanently Close to Their Homes.

Table 1. Results of Coccidioidin Tests of Home-Raised A

Age in Years to Nearest Year	Apache		Cochise		Coconino		Gila (Low Altitude)		Gila (High Altitude		Graham		Greenlee		Ma
	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T
1	78	0	15	1	68	0	291	127	131	0	106	11	107	14	36
2	320	0	80	16	390	0	238	209	374	1	159	34	217	51	38
3	146	0	235	41	21	0	27	14	93	0	91	28	112	21	19
4	40	0	115	17	16	0	16	12	61	0	146	65	45	18	21
5	68	0	108	25	14	0	13	10	32	0	118	54	43	11	15
6	50	0	83	21	7	0	8	5	15	0	92	68	20	14	12
TOTALS	702	0	636	121	516	0	593	377	706	1	712	260	544	129	144
Instantaneous Annual Conversion Rates	0		.05		0		.28		0		.17		.13		.30
Annual Conversion Rates	0		.05		0		.25		0		.15		.13		.26

the 1-2, 94 to the 1-5, 78 to the 1-10, and 37 to the 1-100.

Undiluted coccidioidin was injected in the cervical area of 861 cattle. These skin tests were checked at the following intervals with the following numbers of positives (indurations of over 5 mm.): 24 hours – 310; 48 hours – 380; 72 hours – 455; 96 hours – 505; 120 hours – 435; and 144 hours – 263. Of these cattle, 243 were injected simultaneously in the caudal fold area. The cervical area test resulted in 146 positives at 96 hours and 87 of these same animals had reactions in the caudal fold area. None of the 59 cervical-area negative cattle gave independently positive reactions in the caudal fold area. There were fewer positives both before and after the 96-hour reading.

Simultaneously 264 cattle were injected intradermally in the cervical area with 0.1 ml. doses of undiluted coccidioidin and a control broth handled the same way coccidiodin is in its preparation. The control broth gave negative results in all animals and the coccidioidin gave indurations of over 5 mm. in 131 animals at 96 hours.

From these preliminary studies it was concluded that the coccidioidin should be injected undiluted intradermally in the cervical area and that indurations of more than 5 mm. in diameter at 96 hours would be considered positive.

The skin test agents were injected in many cattle at the same time their blood was being collected for brucellosis serology. In each county some of the same cattle were also tested with other skin test agents – 841 with histoplasmin and 763 with haplomycin.

Table 2. Results of Coccidioidin Tests of Home-Raised Arizona Cattle Classifie

Age in Years to Nearest Year	Altitudes											
	0 - 500 ft.		500 - 1000 ft.		1000 - 1500 ft.		1500 - 2000 ft.		2000 - 2500 ft.		2500 - 3000 ft.	
	T	P	T	P	T	P	T	P	T	P	P	T
1	163	11	79	0	420	126	129	60	534	198	104	
2	149	21	321	35	389	211	119	87	335	278	142	3
3	192	31	177	38	202	161	70	56	114	84	88	2
4	36	9	83	20	191	138	30	24	107	76	133	5
5	30	12	72	30	135	110	31	22	102	78	114	5
6	7	2	38	24	110	105	35	22	24	14	87	6
TOTALS	577	86	770	147	1447	851	414	271	1216	728	668	24
Instantaneous Annual Conversion Rates	.07		.12		.29		.42		.28		.17	
Annual Conversion Rates	.07		.11		.25		.34		.24		.15	

Cattle by Counties — (T = Number Tested, P = Number Positive)

Mohave (Low Altitude)		Mohave (High Altitude)		Navajo		Pima		Pinal		Santa Cruz		Yavapai (Low Altitude)		Yavapai (High Altitude)		Yuma		Totals	
T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
20	10	53	0	304	2	243	71	182	97	211	24	251	18	253	1	163	11	3032	476
35	32	142	1	203	5	97	69	147	130	231	42	110	13	186	2	149	21	3786	805
20	36	71	2	61	1	87	70	106	91	123	27	139	16	131	1	192	31	2041	516
5	8	25	0	52	1	91	64	53	44	46	15	30	4	12	0	36	9	1048	391
5	11	78	1	61	0	89	68	48	41	7	4	23	6	18	0	30	12	954	356
3	23	161	3	41	1	16	9	43	35	11	5	32	19	35	1	7	2	782	315
90	120	530	7	722	10	623	351	579	438	629	117	585	76	635	5	577	86	11643	2859
.11		.003		.003		.27		.41		.12		.09		.003		.07		.10	
.11		.01		.01		.24		.34		.11		.09		.01		.07		.09	

Histoplasmin Lot D-2770 was used in testing 841 of the coccidioidin tested animals. Haplomycin Lot "Phillips 4, antigen 16" was used in testing 763 of the coccidioidin tested animals. These two skin test agents were supplied by Dr. M. L. Furcolow and Dr. R. W. Menges of the Communicable Disease Center. These skin test agents were injected and read by the same method used for coccidioidin.

RESULTS

The results of the coccidioidin tests are summarized in Tables 1 and 2 and in Figures 7 and 8. The conversion rates to a positive reaction for each geographic area were computed by a method outlined by Manos(22). From various areas of each county of Arizona 11,643 home-raised cattle 1-6 years of age were coccidiodin tested and 2,859 (24.6%) were found to be positive.

High annual conversion rates (.24 and above) were found in cattle in the three counties (Pinal, Maricopa, Pima) known to have high human conversion rates. The cattle in the low altitude areas of Gila County were also found to have high annual conversion rates, particularly the areas around the artificial lakes on the Salt River.

Medium annual conversion rates (.11-.15) were found in cattle in the low altitude areas of Mohave County as well as in Graham, Greenlee and Santa Cruz counties.

Low annual conversion rates (.05-09) were found in cattle in the counties of Cochise and Yuma, and the low altitude areas of Yavapai County.

Navajo County and high altitude areas of Yavapai and Mohave Counties had a few coccidioi-

According to Their Home Altitudes — (T = Number Tested, P = Number Positive)

Altitudes															
3000 - 3500 ft.		3500 - 4000 ft.		4000 - 4500 ft.		4500 - 5000 ft.		5000 - 5500 ft.		5500 - 6000 ft.		Above 6000		Totals	
T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
381	28	318	38	55	3	268	1	142	2	162	0	277	0	3032	476
171	21	448	93	125	18	300	2	99	5	103	0	1085	1	3786	805
202	25	235	48	238	41	202	3	29	1	31	0	261	0	2041	516
43	8	91	33	128	23	37	0	21	1	28	0	120	0	1048	391
37	9	50	15	112	27	96	1	19	0	37	0	119	0	954	356
53	35	31	19	88	24	196	4	27	1	12	0	74	0	782	315
887	126	1173	246	746	136	1099	11	337	10	373	0	1936	1	11643	2859
.10		.12		.06		.003		.01		.00		.00		.10	
.10		.11		.05		.01		.01		.00		.00		.09	

din reactors resulting in an annual conversion rate of .01 for each of the three counties.

No coccidiodin-positive cattle were found in the high altitude areas of Gila County nor in Coconino or Apache Counties.

The areas of the State in the altitude range of 1000 to 2500 feet had high annual conversion rates (.24 and above). The rates were lower at less than 1000 feet altitude and became progressively lower with increases in altitudes above 2500 feet so that at 4500 feet the rate became negligible (.01) and at 5500 feet and above it was .00.

Although a few identified herds of cattle at altitudes above 4500 feet had been fed sizable quantities of feed raised in the parts of the State where cattle had high annual conversion rates, only a few animals in these herds were coccidioidin reactors.

Of the 841 cattle tested with histoplasmin, 11 gave positive reactions, but all were also coccidioidin positive. There were 18 cattle positive to haplomycin of 763 tested; these same 18 were also coccidioidin positive. The histoplasmin and haplomycin positive reactions were found in cattle in areas of high endemicity for coccidioidomycosis.

DISCUSSION

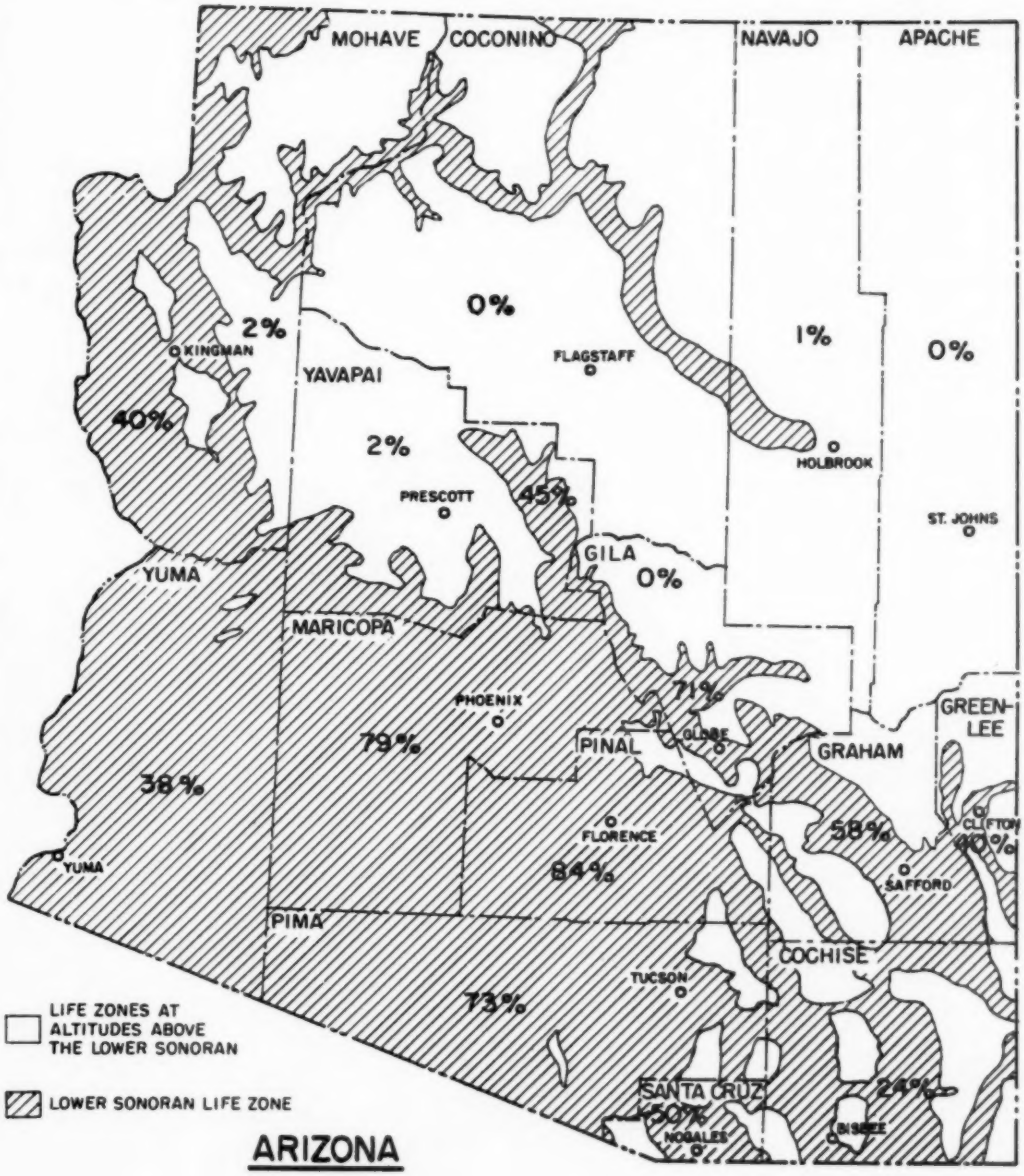
The skin test surveys on humans in Arizona that are summarized in Figures 1 and 2 indicate that the number of infections is greater in south central Arizona than in the northeast part of the State. Figures 7 and 8 on the cattle test data indicate much sharper differences of infectivity of the various areas of the State. The similarity of the endemic area for coccidioidomycosis with the Lower Sonoran Life Zone (a climate zone) has already been discussed(23-25). Figure 9-13).

The Lower Sonoran Life Zone of the Northern Hemisphere has high January and July temperatures and rainfall ranging up to 20 inches per year. The evaluation of three items of climate in combination, the average January temperature, the average July temperature, and the average annual rainfall, yields a good basis for estimating the prevalence of coccidioidomycosis. The July mean temperature (not maximum) of areas of high infectivity is above 80° F. Some infection occurs in areas with July mean temperatures as low as 77° F. but not often below this. The January mean temperature is above 45° F. in areas of high infectivity. Some infections occur where the January mean temperature is as low as 35° F. but not often below this. The annual rainfall is about 5 to 20 inches in the more obviously endemic areas. As rainfall becomes progressively less than 5 inches, infectivity of the area drops. Infections do not occur in areas with more than 20 inches unless there are particularly high temperatures to reduce precipitation effectiveness.

The Lower Sonoran Life Zone in Arizona reaches its coldest limits at just above 5000 feet altitude in most parts of the State. However, the upper limits of the zone are affected somewhat by the latitude and the general slope of the land. Table 2 reveals the gradual drop in conversion rates as the altitude increases above 2000 feet. The areas of the State that are below 1000 feet have high January and July temperatures, but also have low rainfall, usually averaging less than 5 inches per year. These areas appear to be too dry for good propagation of this fungus.

On Figures 7 and 8 the land below 5000 feet altitude along the Little Colorado River between Cameron and Joseph City is indicated as Lower Sonoran. This was classified at one time as Lower Sonoran (26) but later was dropped (27). (Figure 10). Since the only positive animals found in Navajo County were 10 animals at Joseph City (fed locally-raised feed), we thought it best to indicate the difference of opinion on the extent of the zone in this area. No tests were made on cattle in the Grand or Little Colorado Canyons; consequently, there were no positives found to affect Coconino County data.

Comparison of the data for cattle with that for human beings reveals that cattle become infected at about twice the rate for humans living in the same area. A previous Arizona study on man revealed the tendency for the prevalence of positive skin test reactions to level off after 12 years of exposure(17). In cattle it was found that after 6 years of exposure there was also a marked leveling off. Because of this, all animals beyond six years of age were eliminated from



A TOTAL OF 1,736 CATTLE WERE TESTED ON RANCHES SCATTERED THROUGHOUT EACH COUNTY AND ONLY CATTLE THAT HAD SPENT THEIR ENTIRE LIFETIMES ON THE RANCH WHERE BORN WERE TESTED. FOR MOHAVE, YAVAPAI, AND GILA COUNTIES, TWO FIGURES ARE GIVEN. ONE IS FOR ALL TESTS WITHIN THE LOWER SONORAN LIFE ZONE. THE OTHER FIGURE IS FOR ALL TESTS ABOVE THE LOWER SONORAN LIFE ZONE. ALL THE TESTS IN GREENLEE COUNTY WERE IN THE LOWER SONORAN LIFE ZONE. ALL THE TESTS IN COCONINO COUNTY WERE IN ZONES ABOVE THE LOWER SONORAN LIFE ZONE.

Figure 8. This Map When Converted to Human Use Indicates By Counties or Parts of Counties the Percentage of a Human Population Which Would be Coccidioidin Positive After Staying Near Their First Place of Arizona Residence for 12 or More Years. It is Obvious That for Both Cattle and Persons that a Certain Proportion Revert from a Positive back to a Negative Coccidioidin Reaction After Several Years.

Figure 9. Endemic Coccidioidomycosis Areas in the United States as Designated by Smith (9) in 1951. (Reproduction permission granted by California Medicine.)

this study. This leveling off is no doubt related to the reversions of positives to negatives. The annual conversion rates from negative to positive in previous study(17) on humans as calculated by the Manos method was a little less than half that shown for the cattle in this study using the same method of calculation.

The annual rate of conversions to positives among cattle (as calculated by the Manos method) (Figure 8 or Table 1) is almost identical to that found in skin tests of persons in Maricopa, Pima and Pinal Counties(10,12,13) during the first year of exposure. Therefore the rates given on Figure 8 for cattle are quite indicative of the actual percent of a susceptible human population that becomes infected per year for each county.

Comparison of human and cattle data also indicates that the prevalence of coccidioidin sensitivity of cattle 5 and 6 years of age (Figure 7) is about the same as that found when persons with 12 years or more of exposure in the endemic area are tested.

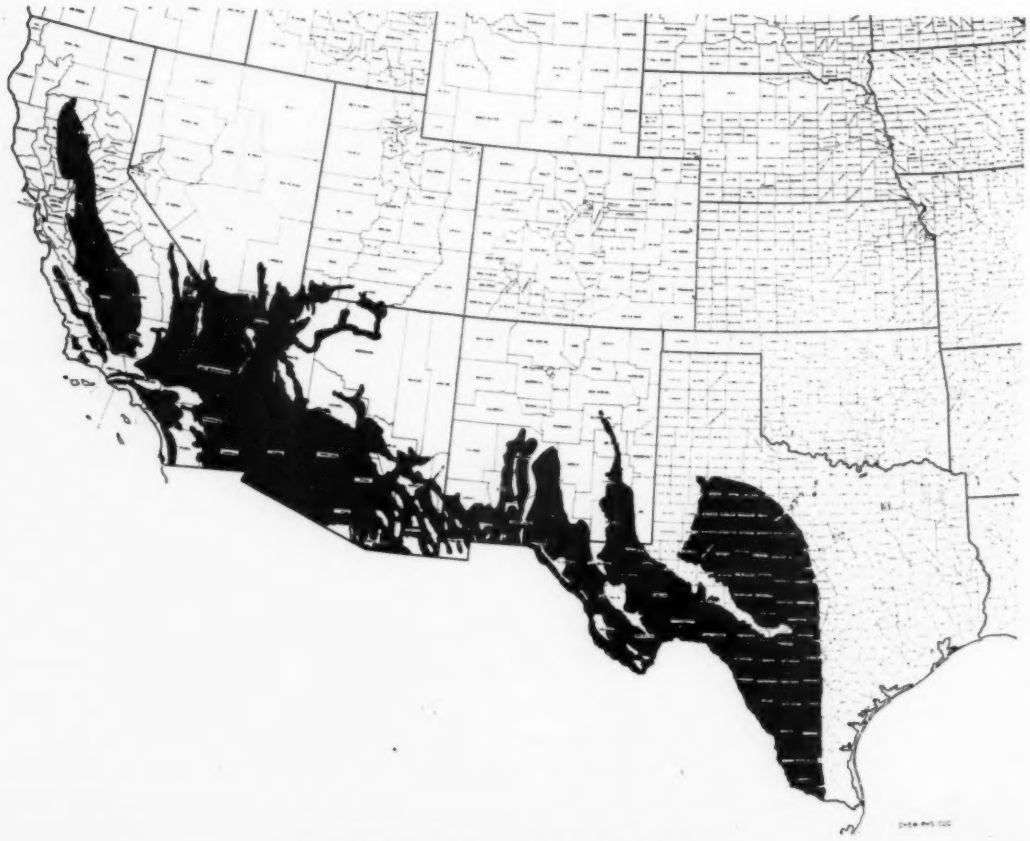


Figure 10. Lower Sonoran Life Zone in the United States.

This study revealed for the first time that the low altitude areas of Yavapai, and Mohave counties and additional areas of Gila county are endemic for coccidioidomycosis. The absence of test results positive only to histoplasmin and haplomycin indicated that all reactions to these two test agents were cross reactions caused by *C. immitis* infections in cattle. Thus it is believed that the cattle tested in this study were not infected with *H. capsulatum* or *Haplosporangium parvum*.

Figure 11. Life Zones of the Colorado River Basin. (Reproduction permission granted by U. S. Department of Interior.)

In this study fomites such as feeds raised in endemic areas did not appear to be good vehicles for transmission of *C. immitis* to cattle fed these feeds in non-endemic areas.

We believe this study has served as an example of how an animal with a limited home range, that also acquires an infection common to man,

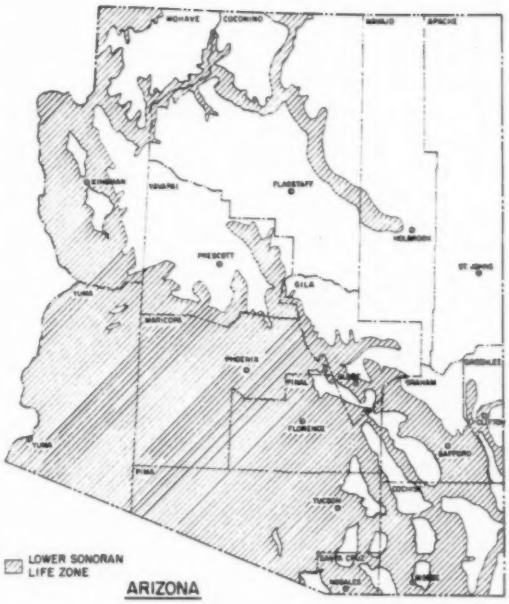


Figure 12. Lower Sonoran Life Zone of Arizona.

can be used to delineate the geographic distribution of the infective agent.

SUMMARY

From various areas of each county of Arizona, 11,643 home-raised cattle 1-6 years of age were coccidioidin tested and 2,859 (24.6%) were found to be positive. Whereas previous human skin test surveys have given only indefinite indications of the extent of the endemic areas, this study revealed rather definite boundaries and the relative infectivity of various parts of the endemic area of the State. The endemic areas were found to be practically coterminous with

Figure 13. The Creosote Bush. This is the Best Indicator Plant of the Lower Sonoran Life Zone in Arizona.

the Lower Sonoran Life Zone.

Some low altitude areas of Gila, Yavapai and Mohave counties were established as endemic areas for the first time and several areas of the State of above 5500 feet altitude previously in a suspect classification were found to be non-infective to cattle.

The annual conversion rates (Manos method) for cattle were found to be almost identical with the actual human infection rates per year in those counties where this relationship was studied. The annual conversion rates of home-raised cattle to a positive coccidioidin test and the prevalence rates of coccidioidin sensitivity by counties in cattle 5 and 6 years of age were found to be fairly accurate predictors of human incidence and prevalence.

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MATERNITY HOSPITAL CARE

The average maternity patient today makes about 10 prenatal visits to her physician, stays about 4.5 days in a hospital at delivery, and spends $272 for all hospital, medical, and similar services used during her pregnancy.

— Health Information Foundation

Emivan, A Coccidioidal Fungicide

Robert Cohen, M.D.

An interesting in vitro study on the fungicidal properties of vanillic diethylamide. This compound may prove of considerable interest and benefit to the problem of disseminated coccidioidomycosis. Further developments should be looked for and clinical research encouraged on this drug.

EMIVAN, vanillic diethylamide, has been reported as a respiratory stimulant. The vanillic radical and the amide radical were obvious in two drugs previously used in coccidioidal infections such as ethyl vanillate and stilbamidine which I had reported(1). On the assumption that this new drug might have some fungicidal properties due to the two mentioned radicals, I decided to try it in vitro studies. Because Emivan can be given both orally and intravenously in doses of 10 mgm per kilogram body weight and its toxicity has already been worked out by other investigators(2), it would make an ideal drug to test for this fungicidal property.

Starting with 2000 micrograms per milliliter, decreasing concentrations of Emivan were placed in Sabouraud's media. They were plated with loopsful of pus from a coccidioidal abscess. The controls were set up without the drug. The petri dishes were set at room temperature and read after the fifth day and every day thereafter for three weeks. The experiment was repeated many times. The controls grew as expected. The fungicidal power was repeatedly shown by complete inhibition of colony growth at 400 micrograms per milliliter. The photograph herein shows this characteristic.

CONCLUSION

Emivan shows definite fungicidal properties for coccidioides immits and completely inhibits its growth at 400 micrograms per milliliter.

From the Department of Pediatrics, Kern General Hospital, Bakersfield, California.

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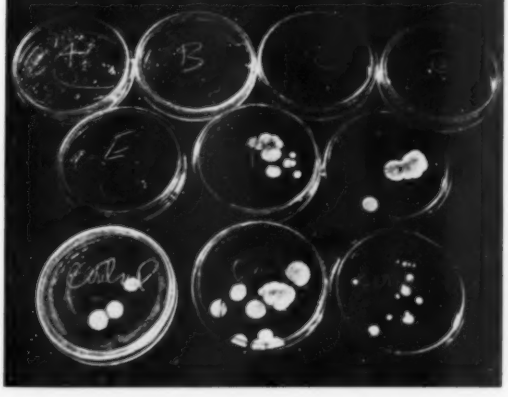


Ureteral Obstruction

Clarence V. Hodges, M.D.

A succinct and comprehensive outline of the causes and most exepditious treatment of the more common types of obstruction of the ureter – describing opaque and non-opaque calculi, tumors, strictures, traumatic severance, and extrinsic pressure. Several excellent illustrations of the roentgenographic findings to illustrate the conditions listed accompany the article.

IT IS A privilege to address this group today and a pleasure to discuss this important urological problem. I should like to limit the topic of urinary obstruction to a specific locale, namely the ureter. In the time available, it will not be possible to discuss all causes of ureteral obstruction but I should like to dwell on four: I. Obstruction from stone; II. Obstruction from intrinsic tumors; III. Obstruction from strictures; and IV. Obstruction secondary to extrinsic pressure. I should like to enlarge upon some of our experiences in diagnosis, particularly with reference to techniques which increase our diagnostic accuracy or which allow us to reach a diagnosis sooner. In the third category, that of obstruction from strictures, I should like to suggest two novel methods of surgical treatment, departures from the classic techniques, which appeal to me by reason of their timeliness and basic logic.

I. OBSTRUCTION FROM STONES

The ordinary ureteral stone presents no serious problems. The symptoms are straightforward. Pain in the costovertebral angle, with radiation around and down in classic fashion, is colicy and periodic in nature and accompanied by gross hematuria. The x-ray in 80 to 90% of patients will show a calcific density lying within the suspected region of the ureter and the diagnosis is evident. Unusual problems are presented by non-opaque stones, stones which overlie skeletal areas and the differentiation of stone from tumor.

Column of contrast material: Often when we have been unable to visualize a calcific density in the path of the ureter, our attention is called in the excretory pyelogram to a column of contrast material which extends from the kidney down a slightly dilated ureter (fig. 1). Successive films continue to show this column of contrast material, always ending at the same spot or with a definite decrease in ureteral caliber below this point. If the story is otherwise typical of ureteral calculus, we have strong reason to believe we are visualizing the site of the obstruction and have indirect evidence that there is indeed a calculus present. We must bear in mind, of course, that any obstruction will give the same sort of ureterogram and must depend upon other means to differentiate these various causes.

Use of oblique films: We are sometimes concerned with identification of a calcific density and would like to know whether it lies within or outside the ureteral lumen. Conventional anterior-posterior x-ray projections will frequently raise the problem by showing a calcific density resembling a ureteral stone and projecting it over the path of the ureter. The use of either the right or left posterior oblique projection or both will settle the question by showing whether the density stays with the ureter or tends to be thrown clearly away from its path (fig. 2,3). At our institution, right and left posterior oblique films are a routine sequence at the 15-minute

Address given at the Veterans Administration Hospital, Tucson, Arizona, February 3, 1960.
Professor of Surgery and Head, Division of Urology, University of Oregon Medical School, Portland, Oregon.

interval following injection of contrast material.

Use of delayed x-rays: Occasionally an intravenous urogram will show lack of visualization of the kidney and ureter on the suspected side in the conventional series of x-rays. The alert physician will request his roentgenologist to take 2, 4, and 8 hour delayed films. Frequently, such delayed films will clearly show concentration of contrast material in the pelvis and in the ureter down to the site of obstruction. (fig. 4,5) Cone-down films over this area or retrograde studies may then indicate the nature of the obstruction.

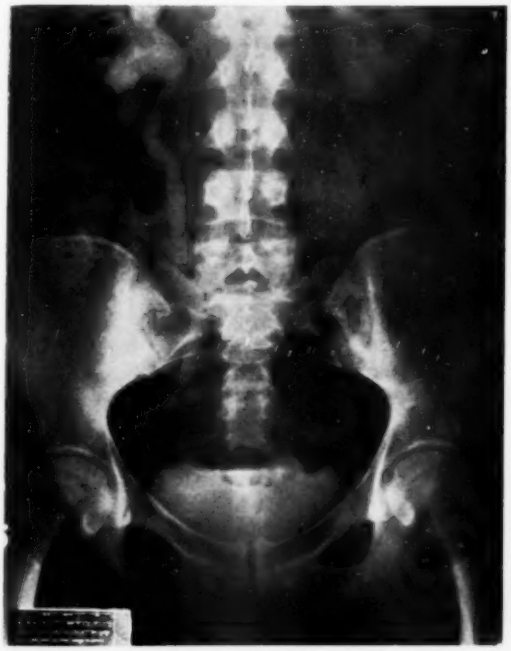


Figure 1: Column of contrast material extends from the kidney down to point of obstruction (calculus) in lower right ureter.

II. OBSTRUCTION FROM URETERAL TUMORS

Primary ureteral tumors are rare; they occur just frequently enough to cause confusion in diagnosis. The onset is insidious and marked only by gross or microscopic hematuria. Frequently they may be hard to demonstrate even though the examiner is alert to the possibility of their presence. In the accompanying illustrative case (fig. 6) hematuria occurred for one year before repeated attempts at ureterograms, knowing which side was involved, demonstrated a small primary ureteral tumor. Our suspicions were heightened in this case by the presence of

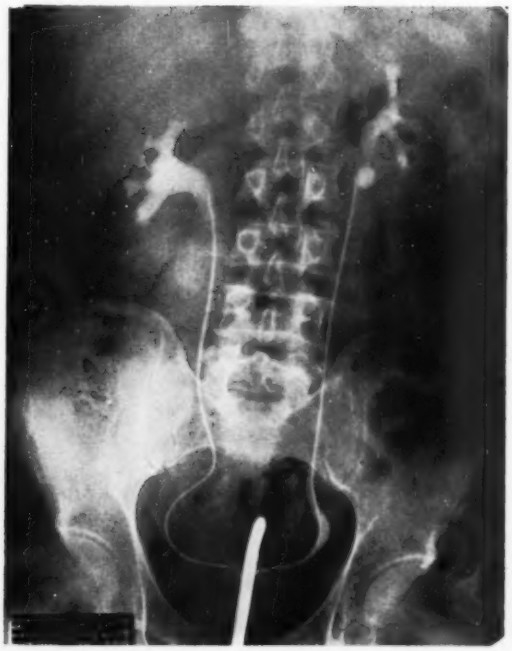


Figure 2: A-P x-ray shows calculus apparently lying in path of left ureter with left ureteral catheter impinging on its infero-medial surface.

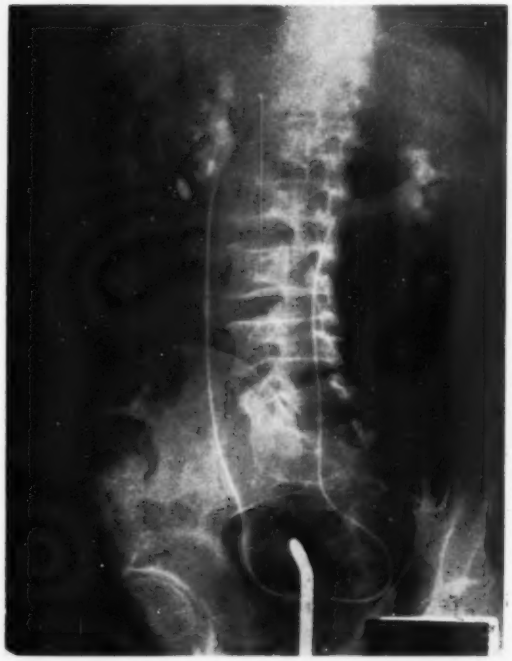


Figure 3: Right posterior oblique projection throws shadow of supposed calculus far to the right, thus ruling it out as a ureteral calculus.

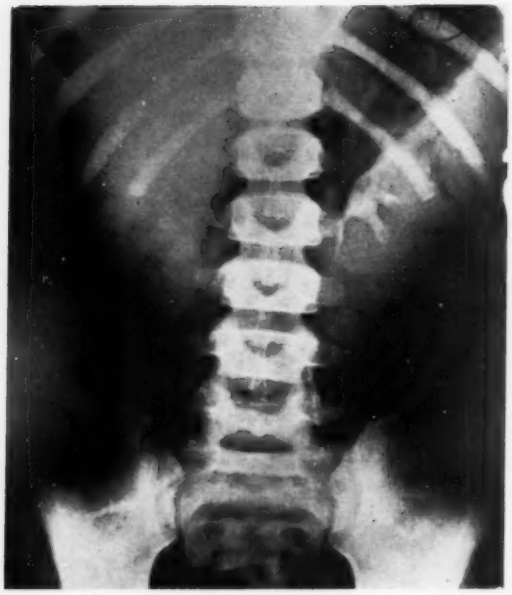


Figure 4: 15-minute film on excretory urography shows normal pattern on left; nephrogram but no clear pelvio-calyceal system on right.

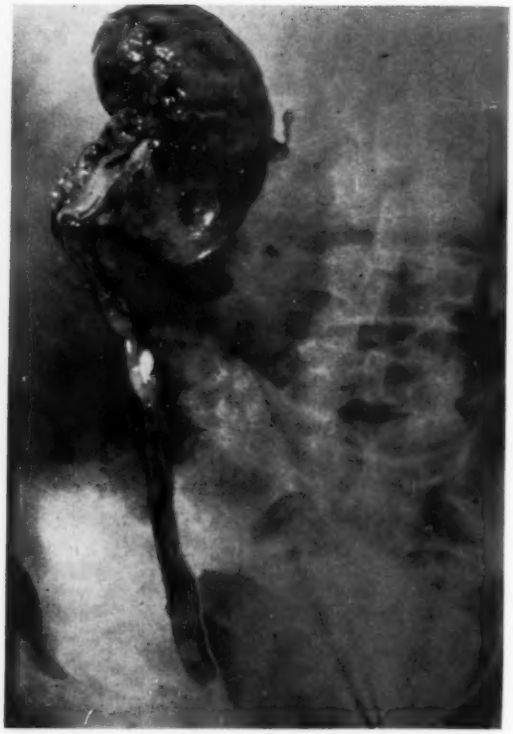


Figure 6: Primary carcinoma of left ureter. Surgical specimen superimposed on x-ray. Note smooth rounded defect in ureterogram at tip of ureteral catheter.

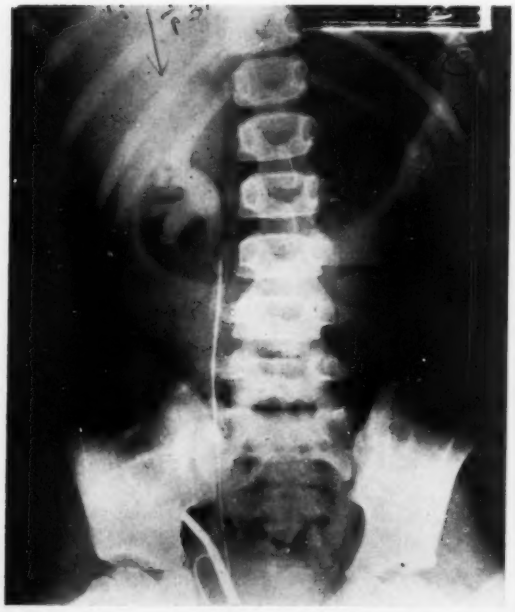


Figure 5: X-ray made three hours after injection of contract material for excretory urogram and **before** any retrograde injection of contrast material. Right pelvio-calyceal outline is clearly seen and column of contrast material extends to point of obstruction just below uretero-pelvic junction.

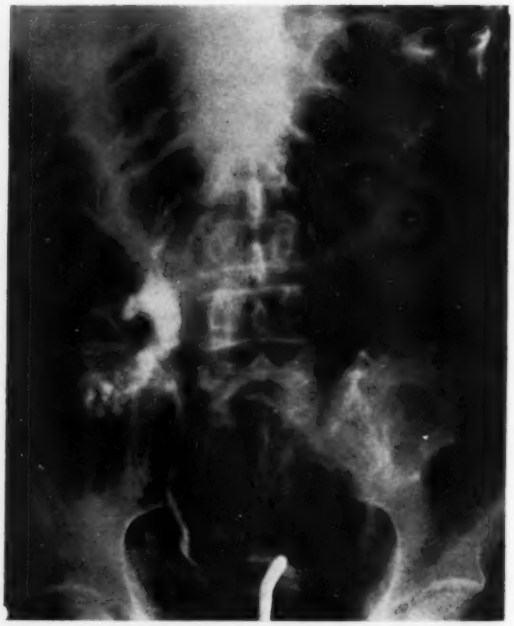


Figure 7: Retrograde ureterogram shows extravasation of contrast material at site of ureteral injury.

a papillary tumor in the bladder five years previously. Roentgenographic visualization of the entire ureter is necessary to rule out a ureteral tumor. Filling defects in the ureterogram are caused by tumor, stone, cyst or air bubbles introduced at ureterography. If a filling defect is consistently present, differentiation narrows down to tumor or stone. The final diagnosis may be made only when the ureter is exposed at surgery.

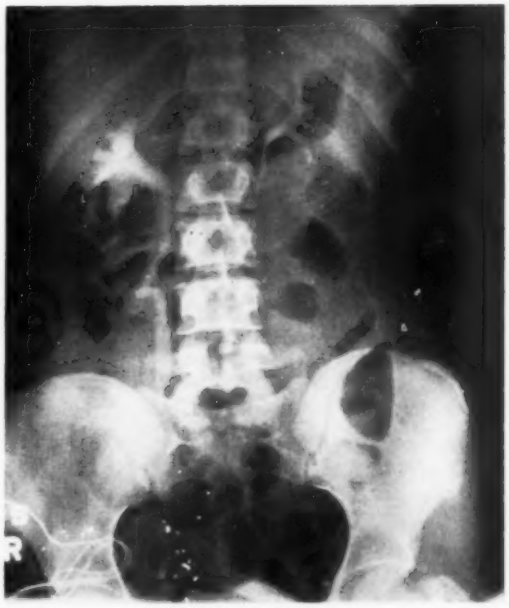


Figure 8: Excretory urogram (explanation in text).

III. OBSTRUCTION FROM URETERAL STRICTURE

Ureteral stricture results most often from injury to the ureter by surgical violation of its integrity during the course of abdominal or pelvic surgery. Ideally, such injuries are recognized as soon as they occur and a definitive repair carried out. Often, however, it is not until symptoms occur in the postoperative period that the occurrence of a ureteral injury is suspected. The symptoms are often non-specific, malaise and poorly localized discomfort, until the appearance of an abdominal or vaginal urinary fistula. Once ureteral injury is suspected, the diagnosis is readily made by retrograde ureterography (fig. 7).

Ureteral repair may be carried out in a number of ways. (table 1) Deligation is the procedure of choice if the integrity of the ureter has not been compromised. Discovery of ureteral occlusion in the immediate post-operative period indicates the necessity for re-opening the abdomen as soon as possible, and repairing the ureter. However, if the injury is not discovered until there is considerable inflammatory reaction around the site of injury or if an abscess has formed, it will be wiser to divert the urine by nephrostomy and postpone definitive repair until after the inflammatory reaction has subsided.

End-to-end direct anastomosis of the spatulated proximal and distal segments of the ureter will be employed if the injury is discovered at the time of initial surgery or in the early postoperative period. In the majority of cases, this will result in a good repair with no stricturing of clinical consequence. An occasional case in which injury is discovered after stricture, with or without urinary fistula, has occurred, impels us to consider other methods for restoring a normal ureteral lumen.

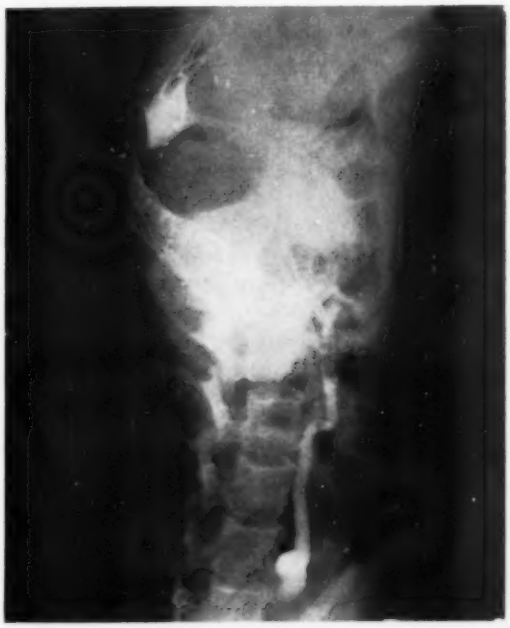


Figure 9: Lateral x-ray after retrograde injection of sinus tract.

Ureteroneocystostomy involves reimplantation

of the ureter into the bladder. As an illustrative case, a 19-year-old girl sustained a gunshot wound, the missile entering the right lower quadrant just above the symphysis pubis and making its exit through the right buttock. At laparotomy, the cecum and small bowel were repaired and the bleeding right uterine artery was ligated. Injury of the right lower ureter was not recognized. A ureteral stricture developed in this area and urine continued to drain from the fistulous opening in the right buttock. Figure 8, an excretory urogram, shows the right hydronephrosis and hydroureter above the site of stricture. Figure 9, a retrograde injection of the fistula in the right buttock, shows the fistulous cavity and its communication with the right ureter. At laparotomy, six weeks after the initial injury, the ureter was transected above the fistulous cavity and reimplanted into the bladder wall near the fundus of the bladder, employing an oblique tunnel through the bladder wall and spatulation of the ureteral orifice. A successful result is seen in the excretory urogram (fig 10) taken six months after the final surgery.

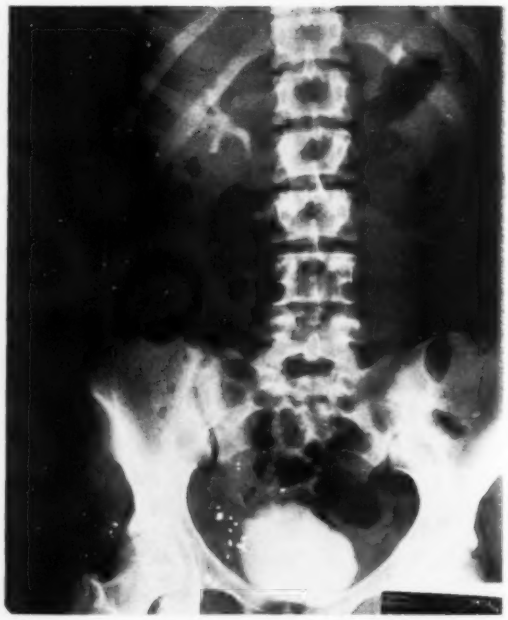


Figure 10: Excretory urogram, 15-minute film, 6 months postoperative.

The preceding case might have been handled by forming a *tube* from a *flap* of *bladder wall* to extend upward to the proximal end of the mobilized ureter. In our experience, however, this technique has been accompanied too frequently by a stricture at the uretero-vesical tube flap anastomosis.

I should like to recommend to you a method that is neither widely known nor used, that of *transuretero-ureterostomy*. The technique involves transecting the injured ureter above the site of injury and mobilizing it proximally so that it can be carried across through a retroperitoneal tunnel to be anastomosed, end-to-side, into the normal opposite ureter. Obviously, the kidney, ureter and uretero-vesical valve apparatus on the "good" side must be perfectly normal. At first thought, one hesitates to jeopardize a normal ureter because of fear that it too may be strictured through some mishap at the anastomotic site. In our series of eleven cases, this misfortune has not been encountered. Ten of eleven cases may be classed as excellent results in every way. In the eleventh case, the transplanted ureter pulled free from the anastomotic side, apparently due to tension, but the normal ureter closed without incident and without stricture. An illustrative postoperative retro-

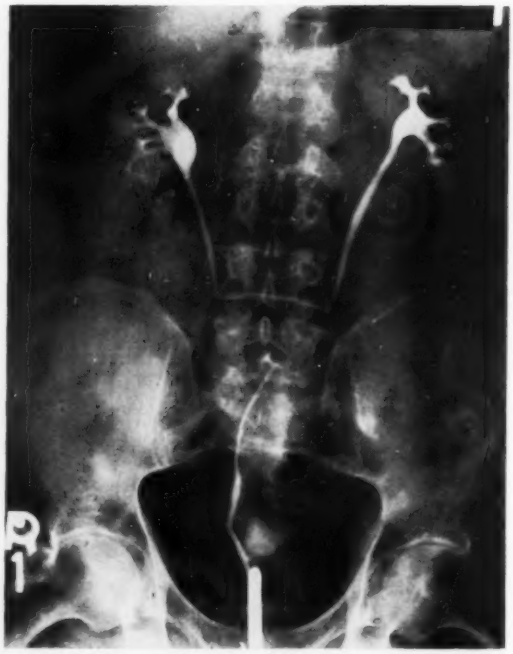


Figure 11: Retrograde uretero-pyelogram, 3 years after transuretroureterostomy.

grade ureteropyelogram from an early case is shown in figure 11.

Isolated ileal segments have been used to replace one or both ureters, partially or completely. This procedure is particularly appropriate where both ureters have been extensively damaged or where through long-standing obstruction or neuromuscular dyskinesia, ureters have lost normal peristaltic function. This procedure is extensive and time consuming; it has been very satisfactory in our experience in the patient with good renal functioin, but should not be attempted in the patient with hopelessly compromised kidneys; his renal reserve may not be sufficient to carry him through the stresses of the long operation and the possible complications of the postoperative period.

Table 1

Treatment of Ureteral Injury

1. Deligation
   a) Early
   b) Delayed
2. Nephrostomy — good temporary measure.
3. Ureterostomy-in-situ — good temporary measure.
4. Ureteral re-anastomosis.
5. Ureteral re-implantation into bladder.
6. Bladder tube flap (Boari-Ockerblad).
7. Trans-uretero-ureterostomy.
8. Ileal substitution and diversion.

IV. URETERAL OBSTRUCTION FROM EXTRINSIC MASSES

Periureteral tumor is the most common cause of obstruction; of these tumors, carcinoma of the cervix is most frequently seen. A persistently recurring problem is whether or not urinary diversion is indicated for the patient whose ureters are blocked by infiltrating tumor masses. I believe that nephrostomies, or other forms of diversion, are not indicated in the patient whose ureters are obstructed if there is no hope of curing the primary disease. Death from uremia is to be preferred to a miserable extension of the patient's suffering by urinary diversion.

In males, prostatic cancer will commonly obstruct the terminal portions of the ureters with encroachment of such a tumor at the junction of the middle and lower thirds of the left ureter. Anti-androgen therapy will frequently relieve such obstruction for long periods of time.

A rather special instance is that of ureteral obstruction from metastases of testicular cancer. Lymphatic drainage of the testes is such that there is a confluence of lymph channels around the hilum of the left kidney. Figure 13 shows the left kidney and upper ureter pushed laterally by a mass resulting from metastases of a seminoma of the testis. Upon irradiation of this region there is a surprising resumption of normal structure and function (fig. 14)

As a final suggestion, extensive damage to the upper portion of the ureter may indicate the desirability of transplanting the kidney to a more favorable location. Clinical application of this method has not yet been reported. In the reported cases of transplantation of the kidney between identical twins and in our own recent successful experience with this procedure, the concept has grown that it would be quite feasible to obviate a long portion of injured ureter by transplanting the kidney into the iliac fossa. The upper ureter could be re-anastomosed to the lower intact ureteral segment or be implanted directly into the bladder. This procedure in dogs is one of the standard exercises for developing facility in kidney transplants and has been done successfully many times. It is possible to obtain a normally functioning kidney with an excellent ureteral attachment to the bladder. We hope to apply this principle in the human patient when the proper clinical situation is at hand.

CONCLUSION

It is apparent that a large repertoire of diagnostic and therapeutic endeavors is available to meet the problems of ureteral obstruction. The basic consideration is preservation of renal integrity. Selection of the proper method requires a background of familiarity with the possible alternative choices.

Medical Society of the United States and Mexico

Annual Meeting - 1961

The Medical Society of the United States and Mexico plans to hold its next meeting in Hermosillo, Sonora, Mexico. The dates have been fixed at December 6, 7 and 8, 1961. Dr. Carlos Tapia, one of our founder members and always one of our most active collaborators, will be our host. Dr. Tapia is currently President of the Sonora State Medical Society. He has forwarded us a tentative program as follows:

December 6, Wednesday

9:00-11:00 A.M. — Registration
11:00- 1:30 P.M. — Scientific program
1:30 - on — Buffet with the Ladies, free afternoon and get together in private homes

December 7, Thursday

9:30- 1:30 P.M. — Scientific program
Trip to Kino Bay (for the Ladies only)
1:30 - on — Dinner with the Ladies, free afternoon, Exhibition of Native costumes

December 8, Friday

9:30-12:00 P.M. — Scientific program
12:00- 1:30 P.M. — Business session
President's address
2:30 P.M. — Governor's banquet with the Ladies
9:30 P.M. — Dance

Hermosillo, as many of our members know, is a clean, modern, small city, the capital of the State of Sonora. It has excellent lodging facilities. Eighty miles farther south is the port of Guaymas, a favorite fishing resort in. the Gulf of California.

The scientific papers have not been secured, and if any of our members wish to assist us by suggesting speakers they are requested to communicate with the Secretary of the Society, Dr. M. A. Carreras, at 130 S. Scott, Tucson, Arizona.

The Executive Committee of our Society has suggested and endorsed a plan at remedying some of the difficulties that have arisen from the inception of the ECFMG examination. This plan has been endorsed by our Mexican colleagues and has been offiically supported by the Dean of the Medical School of the University of Guadalajara, Dr. E. Gonzalez Murguia. Dr. Gonzalez has also undertaken to propose their plan for endorsement of the Association of Deans and Faculties of Mexican Medical Schools which met in the month of May. At this writing no word has been received about their action.

The plan consists in allowing graduates of Mexican Medical Schools, who have not taken the EGFMG examination to occupy positions in U.S. Hospitals in a special probationary category comparable to clerical clerks or observers for an arbitrary period of six months. During that time such clerks would be entrusted with very limited responsibility in patient care, but would be given an intensive course in the English language, as well as a series of lectures on medical topics, supervised clinical tasks such as history taking and physical examinations, assistance at operations, etc. At the completion of such a period of probationary training the clerk would be expected to take the ECFMG examination, the successful completion of which would obligate him to serve the hospital that trained him, for a period of no less than double the length of time he spent in his training, as a full fledged intern or resident. We firmly believe that this plan, in principle, has merit though details of implementation would have to be worked out by the Educational Council itself.

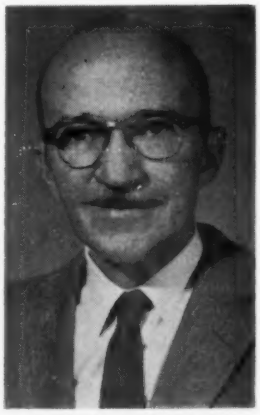
Juan E. Fonseca, M.D.

The President's Page

Address Presented To The Womens' Auxiliary

April 27, 1961

Leslie B. Smith, M.D.



Leslie B. Smith, M.D.

It is indeed a very honored opportunity to have you, the backbone and guiding influence of the medical profession as a captive audience for the next few minutes. I will not steal your time, except as allotted, even though I would prefer a much longer period with you. Without censure, may I propose that yours is yours, or so it was yesterday. But how about Tomorrow?

You, the wives of the guardians of the health of the people have always played a vital part in the fulfillment of the purposes of medicine. This is exemplified by your activities and programs. We are all indebted to you and most appreciate your fulfillment of your obligations. To mention a few of your accomplishments – (1) Nurses Loan Fund, (2) Health Careers, (3) AMEF, and many others. Also, each of you participate in the broad activities of your county auxiliary.

We are most grateful for your cooperation and advice in the actual staging of our annual meetings; this year for your hospitality room, the hobby show, and especially for the money tree. These are ingenious contributions. Thanks a lot.

However, in spite of all your efforts and accomplishments, there are other burdens which should be added to your seemingly full schedules. These I will try to elucidate briefly. You are potent partners of the Medical Profession, and as such, your responsibilities are indispensable.

No jokes today. I am not a comedian. Besides, there is little time for the frivolous. These are serious times, even more so than we have been taught to expect as our heritage.

Today, my remarks will relate to politics. I do not mean partisan party politics, but as it relates to government. Why should politics be injected into a medical meeting such as this? It is axiomatic that the health of the people cannot be separated from their political existence. Whenever government threatens to change the health and welfare, medicine must be vitally concerned. Senator Kerr says, "You doctors can keep out of politics, but you cannot keep politics out of your business."

Our very existence as free people is threatened to extinction, not only as the doctor-team, but as citizens. The destructive forces come from without our boundaries and from within.

Khrushchev has stated that your grandchildren will live under communism. He has also said that "your country (USA) is becoming so socialistic that within 15 years there no longer will be a basis of conflict between our two countries." This is the threat from beyond.

Today, we must seriously be concerned with

the ominous advance of socialism, which will demolish our freedom. We are now faced with the enactment of legislation, the King-Anderson bill, which would socialize a segment of medicine. This Forand type legislation is recognized by non-medical political analysts as the major necessary step before all phases of medicine would fall to the proponents of centralized dictatorial government admnistered by the "New Class" of aristocracy. When medicine becomes socialized, the completion of a socialist state becomes immanent. This is where we must be concerned, not wholly for selfish reasons, but for the equanimity of all.

I need not, and time does not allow that I enlarge on the humbling effect of the Cuban fiasco or how it has lessened the stature and prestige of what we thought to be our peerless country, or how some of our friendly countries have cried out that it is the most degrading thing which has ever happened to the United States. However, these recent happenings, when added to that which has already transpired, does force the question: How could this happen to such a great nation which was assumed to be composed of strong, free, altruistic, educated people, during a time of abundance?

The answer is that our people are sick. They are suffering from a social disease of atrophy of the moral-individuality. It is paradoxical to state that this is a deficiency disease in the land of plenty. We find that the citizens too frequently partake of abundant goodies and have neglected to balance their intellectual diet with facts. During this battle of political ideologies, the public has consumed, by forced feeding, a bunch of fallacious facts and even lies, honeyed-up by the social planners whose prime purpose is the weakening of everyone's moral fiber to create for themselves a nation of atrophied puppets.

A Democratic nation or a Republican government such as ours can be no stronger than its people.

It is indeed fortunate that the deficiency disease from which we suffer is reversible by a balanced diet and specific medication. Yes, we have a specific potion, which if given in proper dosage will neutralize the overdose of venom which has been foisted upon us. This specific remedy is TRUTH. If the people know the truth, with its supporting facts, the direction of misguidance will change and take the road which will continue the freedoms.

We can furnish the cure if we will add action to our sincere objectives. These objectives embrace the preservation and advancement of the health of all.

First, we must be sure that we, ourselves, know the facts. Then we must impart these essentials to all those whom we desire to befriend. Also, we must make a specific effort to express our conviction to those who represent us in government and encourage others to do likewise. This we can and must do. Senator Kerr recently told the medical profession that "unless you do this, be prepared to suffer the consequences."

Time is running short, and we must act now. Speaking of time running short — so is mine. This public educational program is one in which we hope you will participate.

Now, to be more specific about the immediate issues. The Forand Type legislation now before the Congress, H.R. 4222 which is the King-Anderson bill and the administration's alleged bill for the medical care for the aged, is truly socialized medicine because it has been so recognized by the Socialist Party and others.

Your husbands find themselves in an almost defenseless position. Their time is almost completely occupied by their first obligation, the care of the sick. They have little time left over to protect the freedoms of those whom they love, which is not only you, but all of their charges. They cannot forsake the care of the sick because to do so would draw down the wrath of those who choose to villify the medical profession. While the doctors are fully occupied with their dedicated care of the masses, there are those who, with duplicity and herculean effort, seize upon this point of vulnerability to degrade the selfless physician. You can compensate to a large extent this time deficiency.

In Chicago recently I heard Mr. Roger Fleming, Secretary-Treasurer of the American Farm Bureau Federation, give an excellent presentation on the socialistic advances in this country of ours. He stated that in his position and office in Washington, D. C., everyone expected him to know all the answers. He related that he is frequently asked how this race with socialism will come out. His remarks were very enjoyable to me and, I think, appropriate for all of us. He said, "I tell my friends, 'I do not know how the race will end because I am only a jockey. If you

want to know who will win, you will have to ask a bookie. I am only a jockey but, as a jockey, I am giving my horse the best ride I know how. In fact, I am riding Hell out of him.'" In this race – our race – we must give our horse, which is the best, a good professional ride or we will lose.

There is adequate reason for optimism and definitely no reason for the spineless, defeatist attitude which has been adopted by some.

The majority of the congressmen are not in sympathy with further socialization, and particularly with the socialization of medicine. However, because they are sincere in their dedication to represent the majority of their constituents, which also insures their political future, they must know the will of their voters, and this we can cause to be given to them.

The experts tell us that there is time for us to accomplish our purpose, but the time is relatively short and requires action within the next few months.

The Honorable Senator Robert S. Kerr has told us that our cause is right – that we must prevent the socialization of medicine because we or the other citizens will not be free by a program administered in Washington. The administration's bill, called the King-Anderson Bill, H.R. 4222, is such a bill, although it is alleged to be for the medical care of the aged, which it certainly is not.

If I have added a spark to your enthusiasm which will incite needed action and a quest for Know-how, we will all be proud to relate to our posterity that we did our part in the preservation of Freedom and the dignity of Man.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Editorials

Wouldn't Three Be Better?

In an issue of the Arizona Weekly Gazette one of medicine's best friends, Mr. Julian DeVries, has pointed out the need for cooperation between the two professions of medicine and law. He points out that in recognition of this need a group of physicians and lawyers in the Tucson area have formed an organization in an effort to arrive at a better understanding and cooperation. Obviously such a group, in order to be successful, should have at least two motives. The first would be to arrive at a better understanding of each profession's objectives and problems in areas of mutual interest and the second would be to attempt to direct their professional talents in a cooperative effort for the maximum good of the clients and patients whom they serve. This is inded a laudable effort and it is gratifying to know that not only is this being attempted in Tucson but in many other areas of the country as well.

Early in his thesis Mr. DeVries makes the following observation. "Three persons stand ready

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CONTRIBUTIONS

The Editor sincerely solicits contributions of scientific articles for publication in ARIZONA MEDICINE. All such contributions are greatly appreciated. All will be given equal consideration.

Certain general rules should be followed, however, and the Editor therefore respectfully submits the following suggestions to authors and contributors:

1. Follow the general rules of good English or Spanish, especially with regard to construction, diction, spelling and punctuation.
2. Be guided by the general rules of medical writing as followed by the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.
3. Be brief, even while being thorough and complete. Avoid unnecessary words.
4. Read and re-read the manuscript several times to correct it, especially for spelling and punctuation.
5. Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.
6. Exclusive Publication — Articles are accept for publication on condition that they are contributed solely to this Journal. Ordinarily contributors will be notified within 60 days if a manuscript is accepted for publication. Every effort will be made to return unused manuscripts.
7. Reprints will be supplied to the author at printing cost.

to aid the individual in trouble — his lawyer, his doctor, and his spiritual advisor." The third man for this trio, the spiritual advisor, has not gone unnoticed. In several areas of the country physicians and spiritual advisors of many faiths have formed organizations for purposes of better mutual understanding and better service to their patients and parishioners.

With very little thought it becomes quite evident that there are many situations in human experience which combine a great many medical, spiritual, moral and legal factors. Some of the most frequently encountered would be marital problems, divorces, family planning, birth control and artificial insemination for childless couples. Euthanasia periodically comes up for discussion. Even the more common medical procedures such as for example, administration of blood transfusions or various measures for the relief of human suffering can become real problems from not only medical but legal and spiritual viewpoints.

Is it untimely to suggest then, along with sincere commendation for the cooperative efforts of two professions for the maximum good of the individuals served, that the next logical step is for the three professions of medicine, law and the ministry to engage in a similar effort? If two is good, wouldn't three be better?

R. Lee Foster, M.D.

EDITOR'S NOTES

Recent court decisions maintain that when a patient's personal physician is unavailable and the life or health of the patient is threatened, the hospital is responsible to take action of its own.

(James E. Ludlam, counsel for the California Hospital Association)

* * *

Consent forms for surgery must be tailor-made for the specific operation and for this specific patient. Obtain a permit for the specific operation and "to do whatever is deemed advisable or necessary in case some unforseen condition arises in the course of the operation calling in the operator's judgment for procedures in addition to or different from those contemplated." Patient declares he is unaware of specific dangers as enumerated. The patient is requested to leave the choice of the anesthetic to the designated physician-anesthetist and acknowledges that "this is an independent function from surgery." The patient is asked to declare that he is fully informed "of the nature of the surgery, the purposes, the alternatives, and the possible complications." He specifically states, "I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained."

(Dr. Leo J. Adelstein, medical examiner for Los Angeles County)

* * *

. . . Trauma may speed the growth of a tumor, or play a role in its genesis.

(Dr. Bernard Gottfried, Waldemar Medical Research Foundation)

* * *

Postemetic longitudinal tears in the mucosa and submucosa of the cardia of the stomach may cause massive upper gastro-intestinal bleeding. (Mallory-Weiss syndrome.)

* * *

ADVERTISING REVENUE 1961 — The net average down is about 29.2% — January through June, for the State Medical Journal Advertising Bureau Group of 34 journals compared to 1960 (same period).

* * *

DRUG TRADE NEWS reports that Senator Estes Kefauver completed drafting controversial legislation designed to place new curbs on the drug industry. His bill, UPI learned, would require Federal licensing of drug manufacturers for the first time. The Kefauver bill also would: (1) Require manufacturers to give detailed, specific information about their products to doctors; (2) Strengthen inspection of drug manufacturing plants by Federal inspectors, and (3) Relax patent rights on certain drugs, thereby making manufacturing know-how more readily available to competing firms.

* * *

THE FEDERAL TRADE COMMISSION, under Chairman Paul Rand Dixon, is expected to go along with a recommendation on the "old" commission designed to enable FTC to go after promotional materials, including medical journal advertising, distributed to physicians, *Drug Trade News* has learned. FTC has brought few actions against medical journal advertising in the

belief that its jurisdiction in this area is somewhat questionable.

LETTER TO THE EDITOR

Mr. H. C. Warnock's letter to the Editor printed in the April, 1961 issue, stimulated the following comments from this quarter.

Of great concern to physicians and responsible lawyers alike is the developing reluctance on the part of doctors to use a new or unusual treatment in an attempt to help their patient because of certain court decisions which tend to make the physician not only the guarantor of the patient's safety, but results as well.

The godlike quality ascribed to physicians in the past has contributed to this situation. Surely a man who is omnipotent and omniscient could not fail to heal unless he were negligent or careless. Yet, we doctors die of the same diseases we profess to cure.

Recently our halo has slipped in spite of the fact that it is no longer necessary to agonize with the family while a pneumonia crisis runs its course to end fatally or favorably. The crisis never is reached, but the *antibiotic*, not the doctor gets the credit. No human contact in the sharing of an intense emotional experience with the family is available to venerate the physician.

Mr. Warnock could have pointed out that the majority of malpractice cases are conceived through irresponsible talk, gestures or facial expressions on the part of another doctor. The physician who engenders the suit usually has no knowledge of the difficulty the plaintiff encountered, and never bothers to find out the circumstances before rendering a critical opinion.

There are attorneys who point out that favorable testimony which wins the case will insure payment of the doctor bill. Likewise there are doctors whose testimony is influenced by this consideration.

We have no inter-professional problems which honesty, integrity and adult behavior on both sides wouldn't immediately solve. The fact that all problems will never be solved attests to the fact that like the poor, the greedy, the avaricious and the disturbed are always with us. Fortunately they represent a small portion of both our groups as well as our patients and their clients.

Yours truly,
Paul B. Jarrett, M.D.

In Memoriam

Frederick Valles, M.D.

1879 - 1960

Senor Frederick Valles was of the old school. Today's electronic equipment and sterile computer miss much. Medicine has been and forever will be an art, a science, and an amenity. Here was a gentleman physician who was a scholar to his very finger tips.

Although devoted to medicine, his restless mind would not remain in this ivory citadel; he was expendable beyond its confine and expressed himself elegantly as a humanitarian, a poet, a philosopher, a scientist, and a world traveler — in brief he was a man who reached up and in reaching touched a star.

Nonentities never carry the torch of civilization; a small minority of restless controversal minds, perforce enrich and safeguard it.

Doctor Valles was born in Tacna, Peru, where he received his early education at Tacna Lyceum. His Bachelor's degree was conferred in 1904 from the Colegio Vilar in Barcelona, Spain. He received his Doctorate in medicine from the University of San Marcos, Lima, Peru, in 1907. He subsequently studied in many European capitals

Frederick Valles, M.D.

and presented many literary and scientific papers there and in various capitals of South America.

Much of his poetry, essays and scientific contributions were published in Spanish, Italian, French and Portuguese periodicals and journals; thus they have eluded the English press.

He married Emilia Massauguer Lloret in 1903. They enjoyed close upon three decades of marriage before she died, leaving two children, Frederick Jr., and Mrs. Alex (Estela Valles) de Jacome.

Following his training, Doctor and Mrs. Valles traveled the Amazon Territory and practiced in Manaos, Brazil. After two years he established himself in Buenos Aires, Argentina, where he became director of one of the city's leading clinics.

In 1921, he moved to Tucson, Arizona, where he practiced to within a month of his death in December, 1960; along the way, in his journey to the United States through Central America and Mexico, he served as a living link between the medical and literary professions of South America, Mexico and United States. In his time he bridged a chasm that was wider than exists today, for in the late Nineteenth Century a revolution was already brewing, in which wake we are enjoying the fruition of scientific, intellectual and literary achievements. It is not given to every generation to live through this revolution. He saw and partook of a new frontier of science, humanity and intellectualism.

Amidst these crowded years, and this as an index of the magnitude of his medical service in Southern Arizona alone, he delivered over three thousand infants. He is survived by his second wife, Sarah McDermot Gill Valles, as well as eight grandchildren and five great-grandchildren.

This seignior was a visionary. He was a nonconformist. He was controversial, but mark him well as one who stood up to be counted. Now, now at last he is at peace. Ave etque vale!

Edwin A. Busse, M.D.

Topics of Current Medical Interest

Arizona Poison Control Centers

More adequate usage should be made of the two Arizona Poison Control Information Centers now located as follows:

Arizona Poisoning Control Information Center, College of Pharmacy, University of Arizona, Tucson, Arizona. MA 4-8181, Ext. 661. Night: MA 4-6547. Albert L. Picchioni, Ph.D., Pharmacologist and Director. EA 6-2600 Lincoln Chin, Ph.D., Pharmacologist.

Poison Control Center, Maricopa County Medical Society, 2025 N. Central Avenue, Phoenix, Arizona. ALpine 8-8486. Paul B. Jarrett, M.D. Director.

The question has arisen as to the advisability of establishing additional Poison Control Information Centers. These two are readily available by telephone throughout the State. It would seem inadvisable to go to greater expense to establish additional centers. However, more adequate usage should be made of the present ones in the districts that are outlying from these two central points.

Poison Control Treatment Centers are located as follows:

Ajo — Poison Control Center, New Cornelia Hosp. DUdley 7-7261. O. W. Friske, M.D., H. J. Mills, M.D.

Douglas — Poison Control Center, Douglas Hosp., 610 9th St. EMpire 4-2421. C. W. Ahl, M.D., A. J. Rice, M.D.

Flagstaff — Poison Control Center, Flagstaff Hosp., Rt. 1, Box 10. PRospect 4-7151. Doyle R. Taylor, Estelle Wallach.

Ganado — Poison Control Center, Sage Memorial Hosp., Ganado Mission. 2103, Night: 2106. W. D. Spining, M.D., Shirley Roeder.

Grand Canyon — Poison Control Center, Grand Canyon Hospital, Box 495. 14. Watson M. Lacy, M.D.

Holbrook — Poison Control Center, Holbrook Municipal Hospital, 152 W. Hopi Dr. JAckson 4-3731. Night: JA 4-6673. Violet E. Coplan, R.N., Helen Wood, R.N.

Kingman — Poison Control Center, Mohave General Hospital, 301 W. Beale. SKyline 3-2112. Mae McMullen, R.N., Enid McNeff, R.N.

McNary — Poison Control Center, McNary Hospital. 200. Jack I. Mowrey, M.D., Reva Nikolaus.

Phoenix — Poison Control Center, Good Samaritan Hospital, 1033 E. McDowell Rd. ALpine 2-6611. Paul B. Jarrett, M.D., Elizabeth Poulin, R.N.

Poison Control Center, Maricopa County General Hospital, 3435 W. Durango St. APplegate 8-3541. Dudley G. Singer, Archie Kaplan.

Poison Control Center, Memorial Hospital, 1200 S. 5th Ave. ALpine 2-5911, Ext. 216. Maurice Rosenthal, M.D., Conrad A. Bohannon, Juanita Bolen, R.N.

Poison Control Center, St. Joseph's Hospital, 350 W. Thomas Rd. CRestwood 7-6611. Frederick E. Beckert, M.D., Doris Davis, R.N.

Phoenix, General Hospital, 1950 W. Indian School Rd. CRestwood 9-4411. Howard H. Hunt, D.O.

Prescott — Poison Control Center, Prescott Community Hospital. HIckory 5-2700. Edna M. Franks, R.N., Barbara Rambacher, R.N.

Safford — Poison Control Center, Safford Inn Hospital, 625 Central Avenue. 126. R. S. Keller, M.D., Orville F. Craig.

Tucson — Poison Control Center, Pima County General Hospital, 2900 S. 6th Ave. MA 2-3301. Night: EAst 7-3714. Edward H. Kraus.

Poison Control Center, St. Mary's Hospital, St. Mary's Rd. MAin 2-5833. Sister Catherine Mary.

Poison Control Center, Tucson Medical Center, E. Grant Rd. at Beverly Blvd. EAst 7-5461. Virginia Cobb, M.D.

Winslow — Poison Control Center, Winslow Memorial Hospital, 116 E. Hillview St. 289-2821. Night: 289-4444 or 289-3700. Mabyn Peart, R.N., Kay Yecke, R.N.

Yuma — Poison Control Center, Parkview Hospital, Avenue A & 24th St. SUnset 2-1811. John F. Stanley, M.D.

TOXICITY OF SELENIUM SULFIDE (SELSUN) SUSPENSION

In a previous News Bulletin(1), the Arizona Poisoning Control Information Center reported on the contradictory views regarding the toxicity of selenium sulfide (Selsun) suspension. Since a recent clinical report(2) indicates that improper external use of the suspension may result in systemic poisoning, it is considered timely to re-emphasize the potential hazards following the ingestion of this drug. The case involved a woman who used the shampoo treatment two or three times a week for eight months. She ultimately developed signs of selenium poisoning, which included tremor of the arms and hands, severe perspiration, and a metallic taste in the mouth. Others observed that her breath smelled of garlic, although none had been eaten. Subsequent symptoms included continuous pain in the lower abdomen, weakness, lethargy, anorexia, and occasional vomiting. In addition, selenium, approximately 30 micrograms/ml, was detected in the urine.

Although the poisoning case cited above was due to external abuse of selenium sulfide suspension, it serves to point out the potential systemic danger which may attend the oral ingestion of this preparation. Hence, despite the insoluble nature of selenium sulfide and despite the so-called "built-in" emetic action of the suspension, the Arizona Poisoning Control Information Center recommends emesis or gastric lavage in treating ingestion of selenium sulfide suspension.

ACCIDENTAL POISONING FROM ORAL HYPOGLYCEMIC DRUGS

Before the introduction of oral drugs for the treatment of diabetes, hypoglycemia in nondiabetic persons was an uncommon cause of coma, since accidental parenteral administration of insulin was unlikely. At the present time, however, an increasing number of diabetic patients are using oral hypoglycemic drugs; hence these agents can now be found in many homes. Because of their widespread use, these drugs present another potential poisoning hazard for children who should find them readily available in the home.

Youberg(3) recently reported a case of accidental poisoning involving ingestion of chlorpropamide (Diabinese), an oral hypoglycemic drug. The victim was a 2-year-old boy who was thought to have ingested as many as 18 tablets (250 mg each) of the drug. Apparently, the tablets belonged to the child's diabetic grandmother who was living in the same home as the child.

Upon admission to the hospital, the child was unconscious and was unresponsive to pin prick. The initial blood sugar level was found to be 25 mg/100 ml. The patient's initial response to intragastric administration of glucose was satisfactory. He regained consciousness and became increasingly alert. However, 1½ hours after the last intragastric administration of glucose, he had a grand mal seizure and lost consciousness. He was then placed on intravenous glucose, whereupon he slowly regained consciousness. The most satisfactory therapy was found to be 10 per cent glucose in water administered by intravenous drip supplemented by 50 per cent glucose administered intravenously at intervals. The 10 per cent glucose solution was continued until the 2nd hospital day, after which time the patient was maintained on oral feedings. The blood sugar was 55 mg/100 ml on the 3rd day and 99 mg/100 ml on the 4th hospital day. The patient continued to do well and was discharged on the 11th hospital day. Despite the large dose of chlorpropamide, no toxic effects other than hypoglycemia with coma and convulsions were obesrved. This case history points out the long duration of action of this oral hypoglymemic drug and the need for vigorous and continual treatment with glucose in acute poisoning.

Youberg(3) stresses the importance of considering as a potential cause of coma the accidental ingestion of oral hypoglycemic drugs. In fact, it is his usual policy to administer glucose by intravenous infusion to all patients who upon initial examination are disoriented or comatose. His reason for doing this is to ensure a porta

for medication in case of circulatory collapse or other emergency and to provide a rapid therapeutic test for unsuspected hypoglycemia.

STATISTICS OF 87 POISONING CASES IN ARIZONA DURING FEBRUARY 1961

AGE:

75.9% involved under 5 year age group	66
5.7% involved 6 to 15 year age group	5
5.7% involved 16 to 30 year age group	5
9.2% involved 31 to 45 year age group	8
3.5% involved over 45 year age group	3

NATURE OF INCIDENT:

86.2% accidental	75
13.8% intentional	12

TIME OF DAY:

34.5% occurred between 6 a.m. and noon	30
25.3% occurred between noon and 6 p.m.	22
18.4% occurred between 6 p.m. and midnight	16
9.2% occurred between midnight and 6 a.m.	8
12.6% were not reported	11

OUTCOME:

100.0% recovery	87
0.0% fatal	0

CAUSATIVE AGENTS:

	Number	Percent
Internal Medicines		
Aspirin	33	34.7
Other Analgesics	2	2.1
Barbiturates	3	3.2
Antihistamines	0	0.0
Laxatives	2	2.1
Cough Medicine	0	0.0
Tranquilizers	3	3.2
Others	13	13.6
Subtotal	56	58.9
External Medicines		
Liniment	2	2.1
Antiseptics	1	1.1
Others	0	0.0
Subtotal	3	3.2
Household Preparations		
Soaps, Detergents, etc.	0	0.0
Disinfectants	0	0.0
Bleach	5	5.2
Lye, corrosives, drain cleaners	3	3.2
Furniture and floor polish	2	2.1
Subtotal	10	10.5
Petroleum Distillates		
Kerosene	1	1.1
Gasoline	0	0.0
Others	1	1.1
Subtotal	2	2.2
Cosmetics	2	2.1
Pesticides		
Insecticides	2	2.1
Rodenticides	0	0.0
Others	0	0.0
Subtotal	2	2.1
Paints, Varishes, Solvents, etc.	4	4.2
Plants	2	2.1
Miscellaneous	10	10.5
Unspecified	4	4.2
TOTAL	95*	100.0

*The total number of causative agents exceed the actual number of poisoning cases since in certain individual poisoning incidents more than one agent was involved.

1. News Bulletin No. 10, Arizona Poisoning Control Information Center, October, 1959.
2. Ransone, J. W., Scott, N. M., and Knoblock, E. C., Selenium Sulfide Intoxication, New England J. Med. 264:384, 1961.
3. Youberg, D. R., Accidental Ingestion of Chlorpropamide, New England J. Med., 263:1130, 1960.

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CONTAGIOUS DISEASE REPORTING

ARS Title 36, Ch. 6 – Art. 2

36-621. *Report of contagious diseases*

A person who learns that a contagious, epidemic or infectious disease exists shall immediately make a written report of the particulars to the appropriate board of health or health department. The report shall include names and residences of persons afflicted with the disease. If the person reporting is the attending physician he shall report on the condition of the person afflicted and the status of the disease at least twice each week.

36-623. *Report by physician of death from contagious disease*

Physicians shall report in writing to the local board of health or health department the death within its jurisdiction of patients dying from contagious, infectious or epidemic diseases. The report shall be made witihn twenty-four hours after death, and shall include the specific name and character of the disease.

36-630. *Violation; penalty*

A person who wilfully secretes himself or others known to have a contagious or infectious disease, or a member of a board of health or an officer of a local health department who neglects or refuses to perform a duty, or a person who violates a provision of this article or a rule, regulation, order, instruction or measure adopted and given the required publicity by a board of

health is guilty of a misdemeanor punishable by a fine of not less than ten or more than fifty dollars, by imprisonment for not more than thirty days, or both, and if a physician, his license shall be revoked.

Rules and Regulations of the State Department for the Control of Communicable Diseases – Adopted April 11, 1943, Revised March 21, 1951.

Regulation 1. Certain words and terms used in these rules and regulations are defined as follows:

b) *Report of a Disease* – By report of a disease is meant the notification to the State and local health department that a case of reportable disease exists or is suspected of existing in a specified person or persons at a given address.

WHY?

The following motion was presented to the House of Delegates of the Arizona Medical Association on April 26, 1960:

IT IS MOVED THAT Chapter VII, Section 4, of the By-laws, relating to the Benevolent and Loan Fund, be amended by the addition of the following:

"Within five years of the admission of a new member to the Association, he must pay to the Benevolent and Loan Fund the sum of One Thousand Dollars ($1,000). Upon completion of this payment he shall be eligible for the benefits conferred thereunder.

"Every member of the Association shall be assessed dues in the amount of $100.00 annually which shall be added to the Benevolent and Loan Fund."

and IT IS FURTHER MOVED that all present members of the Association shall be assessed the sum of One Thousand Dollars ($1,000) each, payable within the next five years and upon completion of this payment, each such member shall be eligible for benefits under the Fund.

Upon the recommendation of the Committee on Amendments, the motion to amend was referred to the Association attorney and to the proper committee(s) for study. The final recommendations are to be sent to the county societies at least three months before being brought up at the House of Delegates meeting in 1962 for vote.

Why have I made the audacious suggestion that the members of the Arizona Medical Association should assess themselves in such an outlandish fashion? Let me give the first answer by asking another question of each member. If, tomorrow, you were stricken by a totally disabling but not fatal disease and had to retire permanently from the practice of medicine, would you (even with the help of your health and accident insurance which runs out in three to five years) have enough assets 1) to live out your life in decent comfort, 2) to provide for your wife's needs for her lifetime in similar comfort and 3) to provide for the support of your children during their minority and through their years of education? If you can honestly say "Yes", you are in the minority. Most doctors would, I believe, have to answer "No".

Provision for the care of the deceased doctor's surviving family is not too difficult to achieve; term insurance is relatively cheap. It is in the provision for the family in the case of total disability of the doctor that the difficulty arises. I am not alone in finding it almost impossible to pay for enough health and accident insurance to carry on our normal standard of living if I should be disabled. I have a constant, gnawing fear that I might become unable to practice medicine permanently and that, at the end of the three years of my health and accident payments, I might be physically unable to kill myself or mentally incapable of realizing the imperative necessity that I do so.

Morbid thoughts? Of course they are but they are capable of becoming realities. In planning for the future, even such morbid possibilities must be taken into account.

Then there comes the thought of retirement and a second question to be asked of each member. Do you anticipate that you will have enough income-producing investments on which you will retire at a reasonable age to travel, to go fishing or hunting to your heart's content or to indulge in your other interests? Many doctors don't. Many are caught as they approach their retirement years without enough investment income to retire and without stamina enough to earn a good living in the practice of medicine. They find it necessary to eat into their meager investments little by little while still having to work to the top of their capabilities. They finally die in harness and leave almost no estate.

Of course, you know this is not going to happen to you. You are going to save, to invest and to hold down your standard of living to make it possible. This is all very well until your

wife begins to wonder why she can't have a fur coat or why you can have only one car in the family. You are earning enough money to let her remain within shouting distance of the Jones', aren't you? Maybe you finally decide that the reason you hate your patients is that you need a long vacation. Your children reach college age and the educational insurance you took out at their birth isn't nearly enough to pay the costs. You are going to send them through college, aren't you? You are going to give your daughter a fine wedding, aren't you? Where is your saving, your investing, and your stinting then?

Even when you are eminently successful (and lucky) in your ambitious investment program, things can happen. Investments have been known to go sour and to lose all of their value. Even if the investments are all in government bonds, inflation can cut the buying power of the bond income to insufficient levels. So then, you retire using the income and a little of the principal each year. What if you or your wife live too long?

Regardless of the type of investment, other events beyond the control of the doctor may wipe out his investments overnight. A child may run in front of his car, may (unfortunately for the doctor's reserves) survive with amputations and may have a Belli for a counsel. A sympathetic jury, impressed by the histronics and the questionable figures of the lawyer, may find for the plaintiff in the sum of three or four hundred thousand dollars. What good is the doctor's $100-300,000 automobile insurance policy then? What good has the doctor's careful investment program done him then?

The doctor carefully gives a spinal anesthetic. In spite of the doctor's care, the patient is left permanently paraplegic and he very naturally sues. He, too, has a Belli for a counsel and gets a massive judgment. The doctor's malpractice insurance covers only a fraction of the judgment and the doctor's investments go to pay the rest.

Without any investment or interest in the company, the doctor might think it harmless to allow the company to use his name on the Board of Directors. Someone absconds with the assets of the company. The doctor, as one of the few directors with any assets, finds himself with an adverse judgment of $200,000. Looking back, it was an unwise use of his name but, when a close friend is doing the asking, it might be quite understandable. Wise or not, the doctor's investments are just as surely gone.

Are these events so rare? Not if you can believe the men who have the unfortunate doctors as patients. Almost every year, a doctor dies practically unnoticed in this state who, it turns out, has been starving for years and dies without an estate.

Social Security is not a satisfactory answer. It will not help the doctor who is incapacitated before he is fifty. It would not help his widow between the time his children reach 18 and she reaches 62. Even when it did pay, Social Security payments are so small that they are almost useless when compared with the need. I would like to see the aging doctor and his wife be able to do more than starve genteely on about $200 a month. In any event, Social Security is virtually bankrupt now and is apparently due to become more so.

When my proposed amendment reached the delegates to the annual convention, I fully expected a blast of condemnation and scorn. To my surprise, the commonest comment I heard was "We should have done it many years ago." To my further surprise, Dr. Manley had a similarly intended resolution to present quite independently.

The need for something more has apparently long been evident to thinking doctors. The need was evident; only the means of satisfying the need had to be discovered, instituted and implemented.

WHAT TO DO?

Several years ago, the Medical Defense Fund (which had been built up through the years from dues assessed against the members) became obsolete and unnecessary. It was decided at that time to set up a Benovelent and Loan Fund, using the old Medical Defense Fund as capitalization, to serve two purposes. The new fund was to be loaned to deserving students to help them to get a medical education. The loans were to bear an interest rate and, upon repayment, the interest earned was to be used for gifts to needy doctors or their families. Only one fault was quickly evident; there simply wasn't enough capital in the Fund to supply the need for loans and the potential income was too small for any good use.

At the present time, the Fund is all loaned out or committed. It will be several years before

the repayment time begins and, in the meantime, our promise to help needy students must be forgotten. The need for capital to make these loans is demonstrated by the number of loan applications which have had to be rejected for lack of money.

After taking a few whiffs on my favorite opium pipe, I began to THINK BIG!! What if the Benevolent and Loan Fund were really built up to be a large fund? Then we could really fulfill the need of helping deserving students with loans. The income from a large fund could make it a truly Benevolent Fund.

Out of this thinking has come the proposed amendment to the By-laws of the Association.

CUI BONO?

Who would benefit from the Benevolent and Loan Fund as I have visualized it? The answer is simple – everyone who comes in contact with the Fund. There would be ample money available to make loans to every deserving student. Every doctor, his wife and his children would benefit tremendously. Even the Trust Department charged with administering the Fund would love the increased size of the Fund.

Even if I never received a single cent from the Fund, the mere knowledge that the Fund was there, available to me or to my family in time of need, would relieve me of the fear of financial catastrophe. Of course I would try to provide on my own for my family as I am doing now. Of course I would expect never to need any help. *BUT*, if I did it would be there. Every doctor would have this reassuring knowledge that the backstop was there.

The older doctor, reaching his declining years and facing the probability that he cannot continue his hectic pace, will be comforted to know that, if his investments disappeared, he would have the money to keep a roof over his head and ample food in the pot.

The young doctor, struggling to pay off his debts for medical school and for setting up his home and office, will be soothed to know that his death or disablement will not bring financial ruin simply because he could not afford enough insurance.

It has been said that this project is being pushed in order that the older doctors may be able to retire on the Fund. As a matter of fact, as it is presently projected the Fund will not provide enough income during the next ten to fifteen years to promise any doctor that he will be able to retire voluntarily and get anything from the Fund. As far as voluntary retirement is concerned, it is the doctor planning to work for another 20 years or more who may look forward to some retirement income. It is also this younger doctor who has the most to gain in protection against premature death or disability simply because he, his wife and his children are younger and therefore have a long time during which they might need benefits.

HOW?

The motion to amend the By-laws has been referred to the Benevolent and Loan Fund Committee for study. I do not know just what will finally come from the committee to the county societies and finally to the House of Delegates next year. I do have very definite ideas concerning some of the essential (I believe) features which must be incorporated in the plan to make it work properly.

INCOME TAX DEDUCTIBILITY

There is no doubt that the payments into the fund would be much easier to make if they were tax deductible. I believe they will be.

If the assessments are made compulsory, they would be deductible as necessary business expenses. By virtue of interlocking By-laws, it is necessary by hospital rules (in Maricopa County, at least) to be a member of the State Association in order to remain a member of the County Society. It is further necessary to be a member of the County Society to be on the staff of most hospitals. Membership on a hospital staff is necessary to most doctors to practice medicine. Ergo, the assessment is tax deductible.

It is also possible that voluntary contributions to the Fund might be deductible. The State Association is a non-profit corporation and the Benevolent and Loan Fund is a part of it and as such, could be easily declared the proper recipient of charitable contributions. To make sure that the Fund is considered charitable the items discussed in the following paragraph must be part of the plan.

In case of abandonment of the plan at some time in the future, one of the conditions of its establishment must be that no doctor may have any right to recover any of the principal that he has put into the Fund. One method to insure this might be a provision that, in the event of

the abandonment of the Fund, the capital would be contributed to the State of Arizona to help in the establishment of a medical school, its maintenance or its expansion. As a necessary corollary to giving up all rights to his contribution, any doctor who has contributed his $1,000 and who continues to pay his annual Fund dues of $100 would retain his rights under the Fund even if he moves to another state to practice.

Furthermore, there must be no set right to any specific amount of benefits under the plan. The only right a deserving doctor or his family would have would be to receive equal consideration from the Benevolent and Loan Fund Committee who would retain the sole right to determine the size of the gift to be given the deserving donee. With such power to be given the Committee, it is essential that only the finest and most honorable doctors in the state would be considered for appointment to the Committee.

It is my own opinion, based upon what I have read, that, if these conditions are adhered to, not only will the contributions to the Fund be tax deductible but so will the gifts to deserving doctors and their families.

Of course, only when the Fund plan is completed will it be possible to get a final decision from the Internal Revenue Department as to tax deductibility.

SIZE OF ASSESSMENTS

I believe that it is essential that there be a big front end on the assessment. Annual dues alone will build the Fund too slowly to be of much benefit unless the dues be made $200-300 per year. At a straight $100 per doctor per year, it would be 9-10 years before the Fund reached the first million and about 17 years before the two million level would be attained. With the $1,000 initial payment, the first million would be reached before five years and the second by seven years.

PROJECTED GROWTH OF THE FUND

Year	No. of Doctors	Annual Dues Income	Initial $1,000 Income	Cumulative Total in the Fund
1962	1050	105,000		105,000
1963	1100	110,000		225,000
1964	1150	115,000		330,000
1965	1200	120,000		450,000
1966	1250	125,000	1,050,000	1,625,000
1967	1300	130,000	50,000	1,805,000
1968	1350	135,000	50,000	1,990,000
1969	1400	140,000	50,000	2,180,000
1970	1450	145,000	50,000	2,375,000
1971	1500	150,000	50,000	2,575,000
1972	1550	155,000	50,000	2,780,000
1973	1600	160,000	50,000	2,990,000
1974	1650	165,000	50,000	3,205,000
1975	1700	170,000	50,000	3,425,000
1976	1750	175,000	50,000	3,650,000
1977	1800	180,000	50,000	3,880,000
1978	1850	185,000	50,000	4,115,000
1979	1900	190,000	50,000	4,355,000
1980	1950	195,000	50,000	4,600,000
1981	2000	200,000	50,000	4,850,000

Growth of the Benevolent and Loan Fund on the basis of a payment of $1,000 by each member within five years or by each new member within five years after joining the Association and on Annual Dues per member of $100. It is also assumed that there will be an annual net increase of membership of 50 active members.

In reality, these figures would rise even more rapidly. The above chart assumes a total of 50 more doctors a year and no deaths during the next 20 years. In reality, it would be necessary to add 60-70 new doctors a year to ensure a net gain of 50 per cent since some of the members will be dying, retiring or becoming totally disabled each year. This would make the increase derived from the initial payment of $1,000 be $60-70,000 per year rather than the $50,000 cited.

Although, as will be seen from a later paragraph, it will do the more affluent doctor no good to pay his $1,000 before the fifth year of the plan, he might find it advisable to pay his money during an earlier year to offset an unusually good income year.

Are the $1,000 initial assessment and the $100 annual dues too much for the young doctor just starting into practice? From my own experience and from what I've heard, I would say no. I can well remember the joys of hurrying to the bank with a small deposit so that I could pay some overdue bills. Such experiences enlivened the first five years of practice for me. Even so, I could have paid the dues if they had been in existence at the time. Parenthetically, I might say that if a young doctor cannot get together $1,000 in five years and cannot get a bank loan to pay off the balance, he had better leave Arizona. He "ain't doing so good." I would bet that there isn't a single young doctor who couldn't pay $100 his first year of practice, $200 the second, $300 the third year, $400 the fourth and $500 the fifth. With that, his annual dues and his initial $1,000 are all paid. From then on, he coasts at $100 a year. Don't forget, the dues will undoubtedly be tax deductible. Lastly, it is quite probable that the Board of Directors will be given the power to extend the time limit in special hardship cases.

ELIGIBILITY

Eligibility for disaster benefits should probably extend from the payment of the first $100 into the Fund. It is granted that this could mean that a doctor could pay in $100, become disabled and then collect several thousand dollars a year for life. This is a chance we would have to take. Perhaps it would be necessary to make new members above a certain age have a waiting period or present a doctor's certificate of good health in order to become immediately eligible.

Eligibility for voluntary retirement benefits should probably require at least ten years membership in the Arizona Medical Association with at least five of the ten years coming after the institution of the plan. Such a waiting period would be necessary to keep doctors who are already of retirement age from moving to Arizona, contributing their $1,000 plus $100 for the first year's dues and then retiring. A minimum voluntary retirement age of 60 or 65 years of age should be required.

HOW MUCH BENEFITS?

Actuarily, it is probably completely impossible to predict how much each of the beneficiaries could receive from the plan, It would depend entirely on the assets or estates of the doctors who became totally disabled or who died. My own feeling is that, after the fifth year (when the initial $1,000 payments of the present members are all paid) the Fund could guarantee to every disabled doctor or to the surviving wife or minor children of every deceased doctor an annual income of at least $5,000 per year. The guaranteed income could even be higher during years of special need such as the college years of the children.

Every disabled doctor or his surviving family would receive consideration for this income as a right but would have to pass a means test. The benefits would be given from the Fund as gifts.

Benefits to voluntarily retired doctors would come after the needs of the involuntarily retired or deceased doctor's families have been taken care of. If there is still income left in the Fund, each voluntarily retired doctor would receive an equal share of the remainder as a gift and without a means test.

PARTICIPATION BY OTHER STATES

I would not be too unhappy to have the doctors of Nevada, New Mexico or any and all states join in to make a Joint Benevolent and Loan Fund with us. I would say that if, within one year, any other State Association wished to assess their members in similar fashion and join with us, we should welcome them. In fact, if the American Medical Association wished to sponsor such a plan and could get the participation of all the states, this would be the best of all and I would not be averse to adding our present Benevolent and Loan Fund to the national plan to help get it going. If there were such a national plan, it would naturally be administered by state committees under general rules laid down by a national study group.

If a plan such as this were to be started nationally, I'm sure that all talk from doctors urging that the medical profession go under Social Security would suddenly vanish like a morning mist. This plan could offer so much more for so much less outlay that no one would prefer Social Security. All doctors would then speak with one voice and on this subject there would

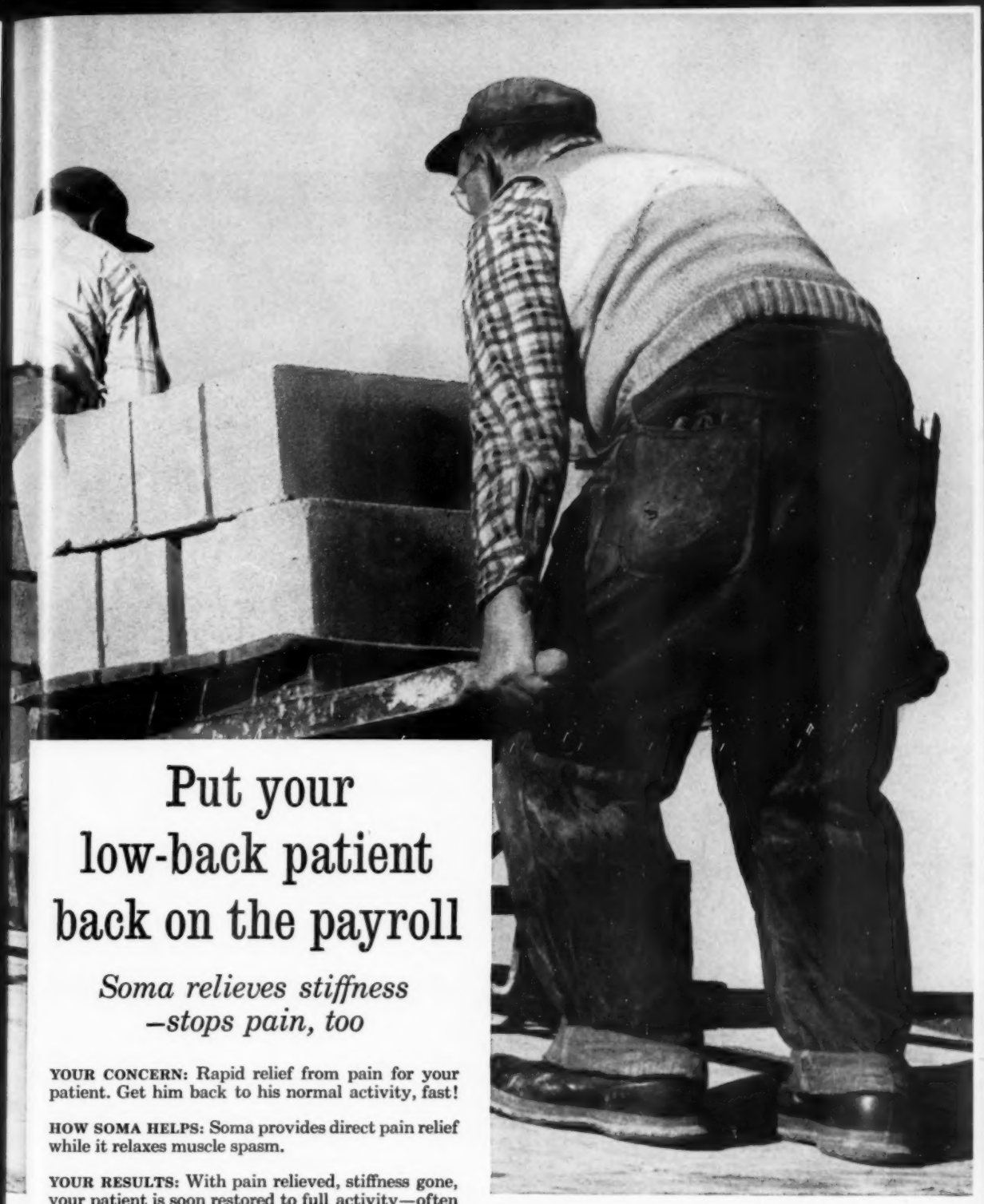
be no question whether the AMA was speaking for all of the doctors.

FINALLY –

I have paid out in the last ten years over $20,000 in health and accident insurance, mortgage insurance, fire and automobile insurance, malpractice insurance and other forms of temporary insurance. I have never collected anything from any of these policies and I'm glad that I haven't. All I have to show for my money is a stack of cancelled checks. I intend to continue to pay for such insurance. However, one-tenth of this amount, paid into the Benevolent and Loan Fund, would have given me more satisfaction than all of this insurance and my capital would still be in the Fund to continue to give me protection.

What the whole proposition boils down to is this, HOW MUCH IS IT WORTH TO HAVE PEACE OF MIND? To my way of thinking, the true peace of mind which this projected fund would provide is worth far more than the average cost of $200 a year in the next 10 years or the average cost of $166.66 over the next 20 years. Although this Fund would not be true insurance, try to find an insurance policy which could do as much for you.

Carl A. Holmes, M.D.
Phoenix, Arizona



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The Herrenvolk Ride Again

NOTES OF A SOVIET DOCTOR. By G. S. Pondoev, M.D., (Translated from the 2nd Russian Ed.) Foreword by Iago Galdston, M.D. 238 pages. New York: Consultants' Bureau, 1959.

"The Soviet doctor is a character unprecedented in the history of medicine. His undoubted superiority over the doctor in capitalistic countries, with his so-called 'free' medical profession, stands out clearly."

This theme recurs in every chapter of Dr. Pondoev's book. The reason for this pre-eminence is clear – at least to Dr. Pondoev; it is the application of the ideas of those eminent physicians and scientists Marx, Engels, and Lenin (why not Trotsky?) to the problems of medical practice, teaching, and research. It is regrettable that Dr. Pondoev nowhere makes it clear how – or indeed whether – these ideas actually apply. However, he does buttress his own views with many allusions to the words or ideas of Pavlov. For example, standing as a separate paragraph in the middle of page 196 is the following pregnant comment:

"I. P. Pavlov taught us that we must never think that we know everything."

There are few who will disagree with Pavlov, or with anyone else who made a similar comment. In the same vein are reiterated statements to the effect that Pavlov's teachings show that loud noises and foul smells are undesirable in a hospital. Pavlov would be outraged, or perhaps amused, by his having been transformed into a god by men whom he despised. The fact that Dr. Pondoev seems to find it necessary to lend support to many trivialities by ascribing them to some Soviet hero is probably significant.

Dr. Pondoev nowhere explains why the great biologists and physicians of Russia – Sechenev, Metchnikoff, Bechterev, Tsion, Kernig, Korsakoff, Wedensky, Pavlov, Maximov, etc. – were able to achieve what they did in the 40 years before the Soviet doctor was created, whereas nothing comparable has occurred in Soviet biology or medical science. (Soviet accomplishments in physics, mathematics, and soil science – the Russians lead the world by far in the last – need no exposition here. These accomplishments merely emphasize (a) that it is not correct to lump all sciences together, (b) that nonbiologic sciences can thrive under a dictatorship, and (c) that biologic sciences, which include consideration of man's relation to his environment, thereby involve matters that the dictatorship reserves as its own; they inevitably come into conflict with the dictatorship and must therefore assume distorted forms.)

Dr. Pondoev's book is full of useful pointers for physicians: Never make a diagnosis without examining the patient; do not accept the doctrines of homeopathy without proof; always undress the patient before examining him or her, making necessary allowances for feminine modesty; never tell a patient in a horrified voice that his blood pressure is 280; be kind to medical students; treat the patient as a whole; etc. The author's repetition of the bald statement that the Soviet physician's aim is to increase the laborers' work output would startle even the most conservative industrialists of this country.

Dr. Pondoev's pitifully naive book is unwittingly one of the strongest arguments against the Soviet system to be found anywhere. Its author either finds it necessary to produce a collection of trivia or else, after 40 years under the Soviet dictatorship, has become unaware that he has produced one.

The reiteration of the idea of the Soviet citizens' superiority and of Western Europe's decadence is strangely reminiscent of the pronouncements of certain Germans who went into eclipse with the collapse of Nazism. However, the ideas

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of their own superiority held by the Communists and the Nazis have different origins. The Nazis, of course, insisted on the inherent superiority of their ill-defined race. The Communists, on the other hand, have adapted to their own purposes the ancient idea of Moscow as "the third Rome."

In the fifth century Constantinople was called "the second Rome." When, in the hope of obtaining aid against the Turks, the delegates of the Eastern Orthodox Church accepted union with the Roman Church at the Council of Ferrara-Florence in 1438-39, the Russians were horrified by what they considered the betrayal of their religion to heretics (D. Strémooukhoff, "Moscow the third Rome: Sources of the doctrine," *Speculum*, XXVIII [1933], 84). The fall of Constantinople shortly afterwards was followed by the growth of the Russians' convictions that they were the only true believers left; Moscow became to them "the third Rome" and Russia was "Holy Russia," "Mother Russia," etc. Its rulers were called czars, i.e., Caesars. "Holy Russia" was believed to have a more legitimate right to call itself the successor to Rome than had the "Holy Roman Empire of the German People" (ruled by kaisers, i.e. Caesars) because the Holy Roman Empire was heretical in the eyes of the Orthodox.

The idea of Russia as the conservator of all true knowledge is therefore an ancient one, and it is no surprise that the present rulers of Russia find it useful. This belief of the Russians has seriously injured the biologic sciences in the territories under their control. It may seriously injure the rest of the world if allowed to spread.

Dr. Pondoev's book has been a great success in Russia.

M.D.A.

NEW DIAGNOSTIC TEST FOR LUPUS ERYTHEMATOSUS

A simple diagnostic test which allows accurate screening of large numbers of patients for disseminated lupus erythematosus in a short time has been developed by public health scientists at the National Institutes of Health, Public Health Service.

A connective tissue disease related to rheumatoid arthritis, lupus erythematosus is far more common than indicated by past statistics. Manifestations may include blood, kidney, or nerve disorders, mental disease, arthritis, and butterfly rash of the face and may appear simultaneously. There may be no serious complications for years, but in its acute, disseminated form, it is frequently fatal.

The test, similar to that devised earlier for rheumatoid arthritis, consists of adding a drop of the patient's serum to bentonite sensitized by desoxyribonucleic acid. If the disease is present, flocculation occurs after about 15 minutes of agitation.

Clinical results are described by John Bozicevich, who heads the Basic Immunology Section, Laboratory of Immunology, and Dr. John P. Nasou and Dr. Donald E. Kayhoe of the Laboratory of Clinical Investigations in the National Institute of Allergy and Infectious Diseases, Public Health Service, reporting in the *Proceedings of the Society for Experimental Biology and Medicine*, March 1960.

Advantages of the test are the elimination of the need for fresh whole blood, required by the cell test, and its high specificity. Six persons with frank rheumatoid arthritis gave positive reactions for lupus with the former test, but all were found negative with the flocculation test. Tests on eight lupus patients were conducted with complete agreement in results with the older procedure. For controls, 138 serum specimens from normal individuals or from patients with related and unrelated diseases were appraised, with negative reactions.

More details of the test appear in the *New England Journal of Medicine* for July 7, 1960.

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About 51 per cent of all maternity patients in this country today see a doctor during the first two months of pregnancy, and 99 per cent of all live births take place in a hospital with a physician in attendance, Health Information Foundation reports.

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